RESURRECTION OF THE PROHIBITION ON THE CORPORATE PRACTICE OF MEDICINE: TEACHING OLD DOGMA NEW TRICKS

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There can be no doubt but that more medical care at a less expensive cost is needed today. However, where the health of the American citizen is at stake, Machiavellian rationale does not and should not apply.

Homer Thornberry[1]

According to court papers, a Saginaw Michigan HMO patient with vaginal bleeding was given antibiotics for five months before her doctor sent her to a gynecologist. The specialist checked her for venereal disease, found nothing and told her to return in a month. However, her primary care doctor refused to approve a second visit. Eight months after her initial visit, she went to an emergency room where doctors performed a biopsy and discovered she had cervical cancer. The HMO had set up financial pools to cover patients' specialist appointments, tests and hospital care. Money left over at the end of the year was split between the doctor and the HMO. According to Circuit Judge Robert L. Kacmarek, ruling on the HMO's motion for summary judgment: "The result was that the fewer referrals a doctor made and the fewer hospitalizations he ordered for his patients, the more money he made."

Los Angeles Times[2]

They paved paradise and put up a parking lot.

Joni Mitchell[3]

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1. Garcia v. Texas State Bd. of Med. Exam'rs, 384 F. Supp. 434, 440 (W.D. Tex. 1974).

2. Daniel Q. Haney & Fred Bayles, *Paying a Price For Cost-Conscious HMOs Medicine*, L.A. TIMES, Jan. 28, 1990, at 3, *available in* 1990 WL 2446298. These facts appear to be taken from the case *Bush v. Dake*, a 1989 unpublished opinion from Michigan, which is reprinted in BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 384 (1991). In *Bush v. Dake*, the judge denied the defendant's motion for summary judgment on the issue of whether the financial arrangements may have contributed to the patient's injuries. *See id.*

3. JONI MITCHELL, *Big Yellow Taxi*, *on* LADIES OF THE CANYON (Reprise 1970).
They paved paradise,—
And put up a parking lot.

I. INTRODUCTION

Most patients, even patients in health maintenance organizations (HMOs),[4] do not comprehend the true magnitude of the changes in the basic relationship between physicians and patients. Patients may believe that they have a more difficult time obtaining services which they and their physicians believe are necessary.[5] However, patients remain largely unconscious about the financial incentives that are designed to encourage physicians to eliminate services which are not "medically necessary."[6] The patient is even less aware of the potential conflict of interest that such financial incentives pose for the physician-patient relationship.[7] When a medical mishap occurs and a

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With a pink hotel, A boutique—
And a swinging hot spot.
Don't it always seem to go
That you don't know what you've got
Till it's gone
They paved paradise.
And put up parking lot.

Id.

4. "An HMO is an organized system of health care delivery for both hospital and physician services in which care delivery and financing functions are offered by one organization. HMOs provide both services to an enrolled membership for a fixed and prepaid fee." Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 20 (1994). As of 1995, there were 550 health maintenance organizations (HMOs) in operation in the United States and 46.2 million people enrolled in HMOs. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH UNITED STATES 1995, 262, tbl.136.

5. *See* Press Release from The Robert Wood Johnson Foundation, *Sick People In Managed Care Have Difficulty Getting Services and Treatment* (June 28, 1995) (on file with the *University of Cincinnati Law Review*) (relating results of survey on non-elderly sick persons conducted over an eleven month period from June 1994-1995 by the Harvard School of Public Health & Louis Harris & A. Associates).

6. "Medically necessary" is the proverbial tail that wags the dog. There are currently close to one trillion dollars spent each year on medical services. There is much speculation about this amount, and whether it reflects the cost of medically necessary procedures. This concept is fairly ill-defined and has undergone some changes which are reflected in the discourse in this Article. At one point, all services ordered by a physician were thought to be medically necessary. The phrase "medically necessary" now generally assumes a definition somewhat akin to the following definition found in the rules and regulations of the Civilian Health & Military Program of the Uniform Services (a health insurance program for members of the military and their dependents): "The frequency, extent, types of medical services or supplies which represent appropriate medical care and but are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy." 32 C.F.R. §199.2 (1997). This language is similar to language found in a typical health insurance policy. *See, e.g.*, Overcash v. Blue Cross and Blue Shield, 381 S.E.2d 330, 335 (N.C. Ct. App. 1989) (contract defines medically necessary as "appropriate with regards to standards of good medical practice").

7. It is generally assumed that HMO enrollees are not generally informed about the financial arrangements between the HMOs and their physicians. *See, e.g.*, Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These To Patients*, 83 GEO. L.J. 1821, 1836. ("Although the patient is likely to know about the use of external controls on medical services like utilization review, most HMO enrollees are unaware of how their providers are reimbursed." (citing CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 122 (1995))).

patient's attorney discovers the financial relationship between the physician and the payer, the patient will feel betrayed.[8] Even if a medical disaster does not occur, a patient apprised of the financial incentives to limit unnecessary care may become distrustful of the physician's judgment.[9] Thus, by means of "Machiavellian"[10] financial techniques, insurance companies may have "managed" care by depriving Americans of a luxury they previously enjoyed: the luxury of believing that you could trust your physician.[11]

At the turn of the century, there was a doctrine that operated as a guardian against the imposition of lay control over the physician-patient relationship. This doctrine is commonly referred to as the prohibition on the corporate practice of medicine.[12] When the doctrine was viable it had two major features: (1) physicians could not be employees of lay organizations, and (2) physicians were prohibited from sharing their fees with lay persons.[13] The articulated rationale behind the rule was that it was necessary in order to prevent lay profit motives from "corrupting medical judgment."[14] The

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8. *See, e.g.*, David R. Olmos, *Cutting Medical Costs-Or Corners?*, L.A. TIMES, May 5, 1995, at A1 (describing lawsuit by deceased patient's husband wherein it is contended that financial incentives caused his wife's death).

9. *See* David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patient's Trust in Medical Care and Their Physicians*, 275 JAMA 1693, 1694 (1996) (noting that disclosure of information about financial incentives to limit care seems more likely to elicit distrust than trust).

10. Machiavelli was a sixteenth century political theorist who posited that politics is amoral and that any means, however unscrupulous, can justifiably be used in achieving political power. *See* MERRIAM WEBSTER'S COLLEGIATE DICTIONARY (10th ed. 1994). The term "Machiavellian" is used to suggest conduct that is marked by cunning, duplicity, or bad faith. *See id.* This phrase was used by the district court in *Garcia v. Texas State Board of Medical Examiners* to describe the perils that the court believed were inherent in allowing lay influence over physicians by overturning the corporate practice doctrine. 384 F. Supp. 434 (W.D. Tex. 1974). It is the premise of this Article that the abandonment of the doctrine has created an environment in which the financing of health care is accomplished by techniques marked by cunning, duplicity, or bad faith. Hence the use of the term "Machiavellian."

11. *See* Mechanic & Schlesinger, *supra* note 9, at 1643 (noting that patients' trust in physicians is threatened by the growth of managed care).

12. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 204 (1982) (noting that between 1905 and 1917, courts in several states ruled that corporations could not engage in the commercial practice of medicine); Mark Hall, *The Corporate Practice of Medicine, in* HEALTH CARE CORPORATE LAW 3-1 (Mark A. Hall & Justin G. Vaughan, eds., 1994) [hereinafter Hall, *Corporate Practice*]; Jeffrey F. Chase-Lubitz, Comment, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445 (1987); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431 (1988) [hereinafter Hall, *Institutional Control*].

13. *See* Hall, *Corporate Practice*, *supra* note 12, at 3-1 ("Corporate practice occurs when administrators hire doctors or when payment for medical services flows from the patient to the corporation before it goes to the doctors rather than in a one-to-one payment relationship between doctor and patient."); Chase-Lubitz, *supra* note 12, at 447 ("Generally, courts hold that the doctrine prohibited corporations from practicing medicine through licensed employees or from realizing profits through the distribution of a physician's professional services.").

14. Hall, *Corporate Practice*, *supra* note 12, at 3-12 ("Because employed physicians are subordinate to the corporation, they may be forced to sacrifice patient welfare for the corporation's profit—maximizing goals. Courts are naturally concerned that this conflict in loyalty would subvert quality of care.").

corporate practice doctrine has been credited with aiding the medical profession in its struggle for autonomy.[15]

Adherence to the corporate practice doctrine, however, would also inhibit physicians from engaging in price competition.[16] Policy-makers and commentators perceived that, therefore, the doctrine stood as an obstacle to health care cost containment.[17] When the nation's health care policy began to focus on cost containment, the corporate practice doctrine fell into disfavor.[18] This Article argues that the current emphasis on health care cost containment requires that we resurrect the doctrine.

The health care delivery system in America involves two primary functions that are inherently and naturally in conflict: the service delivery function and the financing function. The service delivery function is controlled by the physician who makes the decision to consume health care resources.[19] The financing function is performed by private and public payers of health care services. The two activities are inherently antagonistic. If the physician makes a decision that the patient needs a particular medical service, this decision results in a depletion of the financial resources.

The fact that a physician's decision to provide medical care and the duty to finance those services are in conflict means that physicians and payers of health care services will have disputes over health care consumption. This is good because the dynamic ruling physicians' behavior tends to cause physicians to over-utilize health resources,[20] and the dynamic ruling payers' behavior tends to leave some necessary health needs unmet.[21] It is

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15. *See* Chase-Lubitz, *supra* note 12, at 446-70.

16. *See id.* at 476.

17. *See id.* at 479 (noting that "in their efforts to provide medical services in a cost-conscious environment, corporations have introduced alternative systems of health care delivery that are inconsistent with the traditional norms of physician autonomy and that contravene the underpinnings of the corporate practice doctrine").

18. *See infra* notes 49-71 and accompanying text.

19. *See* Elaine Lu, *The Potential Effect of Managed Competition in Health Care on Provider Liability & Patient Autonomy*, 30 HARV. J. ON LEGIS. 519, 527 (1993) ("Though doctors receive only about twenty percent of each health care dollar, they influence seventy percent of total health care spending.").

20. *See* Randall, *supra* note 14, at 15 (noting that traditional reimbursement method created "powerful incentives for all players in the health care system to intervene excessively with overpriced procedures" and that "[n]o one had an incentive to economize"); *see also*, Thomas Bodenheimer, *Reimbursing Physicians and Hospitals*, 272 JAMA 971, 972 (1994) ("Under fee for service reimbursement, physicians have an economic incentive to perform more services, since more services bring more fees.").

21. It is simply not feasible to cover all medically necessary services. Payers respond to this fact by rationing on a macro level by establishing budgets for health care expenditures or by excluding from coverage, or limiting coverage for, certain types of services that are medically necessary. For example, mental health coverage traditionally has been limited. This aspect of the policy to undercover health needs is described as inevitable. *See, e.g.*, Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597, 1603 ("There are limits to what we as a society ought to spend on health care because of other computing social goods that make legitimate claims on [a] finite set of dollars. Hence, the need for health rationing is inescapable."); *see also*, Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 694 ("When we are ill, we desperately want our doctors to do everything within their power to heal us, regardless of the costs involved. Medical technology has advanced so far, however, that literal adherence to this credo for everyone would consume the entire gross domestic product.").

appropriate that disputes over the provision of medical services be explicit and that the resolution of such disputes be salient. Utilization review is the process by which a payer determines if medical services are appropriate and necessary.[22] This may include requiring a physician to obtain approval from the payer before providing certain types of care, particularly, referrals to specialists or admissions to hospitals for in-patient treatment. This process can be highly contentious, but it is the type of salient process required to address disputes over treatment decisions. However, this process, because of its visibility, has fallen into disfavor as payers opt for more subtle means to contain health care costs.

In the new health care environment, health care financing increasingly involves arrangements that shift some of the financial risk of health care expenditures from insurance companies and other payers of health care services to physicians and other providers.[23] "Risk sharing," as these arrangements are known,[24] imposes some of the financing function on physicians. It is the contention of this Article that risk sharing is either: (1) dangerous because it is designed to alter physician decision making, or (2) dishonest because it is merely a covert means to transfer the cost of providing health insurance coverage from insurers to physicians.

Because of their training and expertise, physicians operate as fiduciaries.[25] By imposing the financing function on physicians, risk-sharing arrangements potentially undermine the integrity of physicians' exercise of their fiduciary obligations to patients.[26] Risk sharing presents the physician with a

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22. *See infra* note 84 and accompanying text.

23. *See, e.g.*, Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There A Conflict of Interest*, 317 NEW ENG. J. MED. 1743 (1987). In this article, Dr. Hillman reported the results of a survey he conducted in 1987 in which he mailed a questionnaire to the 595 HMOs known to be in operation as of 1986. *See id.* at 1744. Fifty-one percent of the HMOs responded. *See id.* Of the respondents, forty-six percent paid their physicians pursuant to the capitation method. *See id.* at 1745 tbl.2. Sixty-six percent withheld some percentage of the physician's fees. *See id.* at 1746 tbl.3. Capitation and fee withholding are two mechanisms by which HMOs shift financial risk to physicians. *See infra* notes 102-14 and accompanying text; *see also* Randall, *supra* note 4, at 30-31.

24. *See infra* notes 102-14 and accompanying text.

25. *See* Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients From Their Physicians*, 55 U. PITT. L. REV. 291, 348-49. (1994) ("Fiduciary relationships are generally described as those in which some aspect of the relationship between parties justifies the imposition of special obligations on one of them. Several treatises on fiduciary law name the physician-patient relationship as a fiduciary one and the courts have tended to concur." (citing J.C. SHEPHERD, THE LAW OF FIDUCIARIES, 29-4 (1981) and Thomas H. Boyd, *Cost Containment and the Physician's Fiduciary Duty to the Patient*, 39 DEPAUL L. REV. 131, 135 (1989))). In at least one instance, this fiduciary relationship has been defined by statute. The Texas Commercial Bribery Act provides that a fiduciary commits a felony "if without the consent of his beneficiary, he intentionally or knowingly solicits, accepts, or agrees to accept any benefit from another person—on agreement or understanding that the benefit will influence the conduct of the fiduciary in relation to the affairs of his beneficiary." TEX. PENAL CODE § 32.43(a)(2)(c) (West 1994). The Texas Commercial Bribery Act defines the term "fiduciary" to include a physician. *Id.*

26. Much has been written on the conflict of interest inherent in risk sharing arrangements. *See, e.g.*, MARC A. RODWIN, MEDICINE, MONEY AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST 136 (1993).

> Paying physicians to act as cost-control agents for third parties pits the interests of physicians

choice—deny care or subsidize the cost of that care. Reassertion of the corporate practice doctrine would restore the separation of the service delivery function and the financing function.

Even if risk sharing does not alter physician conduct, it does allow insurance companies to export some of the cost of doing business to physicians. Because the risk-sharing arrangements that are prevalent are designed to reward and punish aggregate behavior, the actions of an individual physician do not have an effect on the physician's finances.[27] The individual physician remains powerless to influence the impact of the risk-sharing arrangement. To the extent that risk sharing shifts costs to physicians, the practice allows insurance payers to operate as beneficiaries of a hidden subsidy, as a portion of its costs are underwritten by the medical profession. In this sense, risk sharing is dishonest.

Risk sharing also creates an additional hidden subsidy for the insurance industry by allowing payers to distance themselves from explicit rationing decisions. Risk sharing, in effect, balances the cost containment agenda on the backs of American physicians.[28] This is done by making the physician the payers' de facto health care rationing agent.[29] Therefore, risk sharing masks the hidden psychic, as well as financial, costs associated with private sector health care financing.

Unfortunately, the federal government has become a willing participant in the risk-sharing strategy. The federal government has undermined the corporate practice doctrine[30] and has adopted risk-sharing strategies of its own.[31] The federal government needs to embrace the prohibition on the corporate practice of medicine in order to prevent insurance companies from

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> against those of patients. It motivates physicians to consider their own financial interests in balancing the concerns of payers and patients. And it compromises the ability of physicians to offer patients disinterested professional advice.

Id.

27. *See infra* notes 130-35 and accompanying text.

28. *See* Hall, *supra* note 21, at 716. In his article, which supports some degree of health care rationing by physicians, Hall states:

> The alternatives to internalizing cost constraints in physician's clinical judgments are either to force patients to make their trade-offs themselves by preventing them from purchasing insurance or to allow private insurers and employers, driven by profit-making concerns, or government, driven by budget-deficit concerns, to impute cost constraints explicitly by rule based oversight of medical practice.

Id.

29. *Id.*

30. *See infra* notes 62-71 and accompanying text describing impact of Federal HMO Act of 1974 and Federal Trade Commission Antitrust enforcement on corporate practice of medicine doctrine.

31. The federal government is the payer under two federal programs for health services: Medicare and Medicaid. Under each of these programs, HMOs may contract with the federal or state government to accept payment on a prospective basis, rather than a fee-for-service basis. Enrollment in Medicare HMOs has increased from 400,000 in 1980 to 2.9 million in 1995 (from 4.3% of total HMO enrollment to 8%). *See* U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 262, tbl.136. Enrollment in Medicaid HMOs rose to 3.3 million in 1995. *See id.*

shifting the financing function to physicians. Only then can we reveal the true costs of maintaining the system of private health insurance.

Part II of this Article will examine the premises underlying the corporate practice of medicine doctrine. This Part will reveal that the doctrine resulted from a mixture of protectionist motives on the part of organized medicine and an idealized conception of the physician-patient relationship by the courts. Part III will examine how federal policy helped lead to the demise of the doctrine. This Part will reveal that the federal government was more concerned about cost containment than with preserving an idealized physician-patient relationship. Part IV will describe the financial risk-shifting mechanisms that have arisen in response to the need to control health care costs. Part V will explain how risk sharing is either dangerous because of its potential to alter the physician-patient relationship, or dishonest because it merely allows private sector payers to benefit from a hidden public subsidy. Part VI will examine how a healthy respect for the rationales underlying the corporate practice doctrine would lead to a prohibition on risk-sharing arrangements. Part VII then describes the inadequate federal response to risk-sharing arrangements. Finally, Part VIII describes why the danger and dishonesty of risk sharing cannot be ameliorated by any means other than a blanket prohibition on the practice.

II. WHEN TITANS CLASH, ROUND ONE: THE CORPORATE PRACTICE DOCTRINE VS. COST CONTAINMENT

On July 30, 1972, a group of individuals from San Antonio, Texas attempted to file articles of incorporation with the Texas Secretary of State for the purpose of incorporating a nonprofit corporation known as the San Antonio Community Health Maintenance Association (SACMHA).[32] These individuals intended to use SACMHA to provide medical and health care programs to Mexican-American and black communities and other low-income groups in Bexar County, Texas.[33] The Articles of Incorporation envisioned that SACMHA would be empowered to "contract for the employment of licensed physicians on a salary basis to work for [SACMHA] as employees."[34] The problem with the proposal to hire physicians as employees on a salary basis was that none of the incorporators were licensed physicians. Therefore, SACMHA's Articles of Incorporation were in conflict with Texas statutes that, as interpreted by Texas courts, prohibited the corporate practice of medicine, which included a prohibition on employing physicians on a salary basis.[35]

The Texas Secretary of State refused to grant a charter for SACMHA. The incorporators brought suit in federal court alleging that the state's prohibition

32. *See* Garcia v. Texas State Bd. of Med. Exam'rs, 384 F. Supp. 434, 435 (W.D. Tex. 1974).
33. *See id.*
34. *Id.*
35. *See id.*

on the corporate practice of medicine violated their right to equal protection under the Fourteenth Amendment and their freedom of association under the First Amendment.[36] While recognizing the need for low cost medical services, which the plaintiffs were attempting to address by incorporating SACMHA,[37] the district court upheld the prohibition on the corporate practice of medicine in *Garcia v. Texas State Board of Medical Examiners*.[38]

In rejecting the plaintiffs' claims, the court relied on various theories that courts had traditionally used to articulate and enforce the prohibition on the corporate practice of medicine. The court stated "'[t]o practice a profession requires something more than the financial ability to hire competent persons to do the actual work. It can be done only by duly qualified human being, and to qualify something more than mere knowledge or skill is essential . . . No corporation can qualify.'"[39]

Garcia's reasoning echoed a branch of cases which held that the prohibition on the corporate practice of medicine was supported by state licensing statutes that required a license to practice medicine. The reasoning was that "[c]orporations cannot possibly qualify for a medical license because the applicant must demonstrate moral character and professional competence. Corporations, of course, do not have a moral character, cannot attend medical school, and cannot be tested."[40] Therefore, corporations could not obtain a license to practice medicine. The court reasoned that because corporations could not practice medicine directly, they also could not do so indirectly by employing licensed physicians.[41]

This reasoning is rather tenuous. The argument that a corporation cannot practice medicine because it cannot obtain a license is like saying that a corporation cannot engage in trucking because a corporation cannot obtain a driver's license.[42] The argument that a corporation cannot practice

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36. *See id.*

37. *See id.* at 439-40 (noting a "grave shortage of doctors" and a need for "more medical care at a less expensive cost").

38. *Id.* at 440.

39. *Id.* at 438 (quoting *Dr. Allison, Dentist v. Allison*, 360 Ill. 638, 196 N.E. 799 (1935)) (alteration in original).

40. Hall, *Institutional Control*, *supra* note 12, at 512; *see also*, Chase-Lubitz, *supra* note 12, at 465 (noting that "[c]ourts that derive a rule against corporate practice from statute requiring license hold that a corporation's non-personal nature prevents it from meeting the qualifications of the licensure statute and therefore prevents it from practicing medicine").

41. *See* Hall, *Corporate Practice*, *supra* note 12, at 3-10 (noting that such courts reason that corporations which employ physicians violated licensing laws by reason of the agency law notion that acts of the employees are attributable to the employer).

42. *Id.* at 3-20. Hall concludes that there is not really a sound statutory basis for the corporate practice doctrine. Few statutes specifically address the issue, and courts have pieced together an implication based on reasoning that Hall characterizes as either formalistic or obvious sophistry. To emphasize his point, Hall observes:

> The argument is no more sound than the argument, say, that corporations who hire truck drivers are engaged in driving without a license because:
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> - The actions of drivers hired by a corporation are attributed to the corporation;
> - an eyesight examination is required for a driver's license;

medicine because it cannot obtain a license represents a judicial attempt to avoid making public policy.[43] It reflects one line of reasoning that courts used in the corporate practice cases—a somewhat tortured reading of a licensing law to achieve the court's rather thinly veiled public policy agenda.[44]

The *Garcia* court also noted that "[t]he Texas legislature seeks to preserve the vitally important doctor-patient relationship, and prevent possible abuses resulting from lay person control of a corporation employing licensed physicians on a salaried basis."[45] The court reflected:

> While it is no doubt true that this nation faces a grave shortage of doctors, is the panacea to be found in the formation of non-profit layman corporations? We think not. It appears to the Court that not only is such a corporation fraught with practical and ethical considerations, but may well represent a backward step in the legislative protections it has taken so long to achieve. Without licensed, professional doctors on Boards of Directors, who and what criteria govern the selection of medical and paramedical staff members? To whom does the doctor owe his first duty—the patient or corporation? . . . Who is to dictate the medical and administrative procedures to be followed? Where do budget considerations end and patient care begin?[46]

These statements underscore the public policy concerns that courts have used to support the prohibition on the corporate practice of medicine. Lay control over the physician's professional judgment, commercial exploitation of the medical practice, and division of the physician's loyalty between patient and employer are rationales that courts have advanced to prohibit the corporate practice of medicine.[47]

Implicit in these public policy concerns was a belief that the profit motives of lay persons should not interfere with the sanctity of the physician-patient relationship. As one commentator noted:

> The fidelity of the physician-patient relationship has long been viewed as crucial to the practice of medicine. The introduction of a third party into that relationship could divert the physician's loyalty from the patient to the third party compensating the physician. Consequently, the physician might be more concerned with the

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- corporations cannot take an eye exam;
- therefore, a corporation that hires drivers is guilty of driving without a license.

Id. at 3-20–3-21.

43. *Id.*

44. *Id.*

45. Garcia v. Texas State Bd. Med. of Exam'rs, 384 F. Supp. 434, 438-39 (W.D. Tex. 1974).

46. *Id.* at 439-40.

47. *See* Chase-Lubitz, *supra* note 12, at 467.

> interests of the corporation's investors than with the interests of the physician's patient.[48]

Thus, the court's opinion in *Garcia* relied upon the traditional grounds upon which the judiciary had supported (and created) the prohibition on the corporate practice of medicine. *Garcia* is instructive because it involves the application of the doctrine in the context of the modern concern with health care cost containment. In *Garcia*, the court's upholding the doctrine had the effect of preventing the implementation of an innovative health care delivery system that would both contain health care cost and expand accessibility of services. It was the fact that the doctrine presented an obstacle to such cost containment measures that hastened its demise.

III. WHEN TITANS CLASH, ROUND TWO: THE CORPORATE PRACTICE DOCTRINE VS. THE FEDERAL GOVERNMENT

The corporate practice of medicine doctrine was a creature of the organized medical profession, state legislatures, and the courts.[49] The doctrine is credited with helping to raise the standards of the medical profession and protecting the public from quackery.[50] It is credited with doing much to establish the sovereignty of physicians.[51] However, viewed in another light, the doctrine was foisted upon the unsuspecting public by organized medicine to preserve physicians' financial well-being by protecting physicians from competition.[52] When the protectionist aspects of the corporate practice of medicine doctrine came into conflict with the federal concern about the increasing cost of medical services, the federal government responded by undermining the doctrine.

The prohibition on the corporate practice of medicine found its genesis in ethical codes of organized medicine. The ethical code was

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48. *Id.* at 470.

49. *See generally id.* at 445.

50. *See Garcia*, at 437-38. ("Historically, such remedial statutes have been adopted as a result of hindsight and in the wake of a stream of public abuse at the hands of entrepreneur medicine man purveying his snake oil elixir.").

51. *See* STARR, *supra* note 12, at 199-232. This section describes the organized medical profession's resistance of corporate control between 1900 and 1920. This resistance contributed to maintaining the professional sovereignty of physicians.

52. Chase-Lubitz, *supra* note 12, at 457-58 (noting that "contract practice" and "corporate practice" threatened organized medicine's monopolistic designs by creating competition); *see also* STARR, *supra* note 12, at 215-16 ("Doctors opposed corporate enterprise in medical practice not only because they wanted to preserve their autonomy, but also because they wanted to prevent the emergence of any intermediary or third party that might keep for itself the profits potentially available to the practice of medicine.").

part of organized medicine's early effort to "establish the preeminence of the regular medical profession in the provision of health care by imposing higher standards on the profession and by distinguishing it from sectarianism and quackery."[53] The young profession was aided in this endeavor by state legislatures that adopted licensing statutes which prohibited the practice of medicine without obtaining a medical license, and judicial interpretations of such statutes.[54]

As part of the effort to distinguish physicians from pretenders, the ethical code promulgated by the American Medical Association (AMA) consistently and jealously guarded against inroads into physicians' autonomy. The AMA's ethical codes initially prohibited physicians from engaging in financial arrangements that made it "impossible to render adequate service" and that "interfere[d] with reasonable competition among the physicians of a community."[55] The AMA revised its ethical code in 1934 by the addition of the following proscription:

> It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.[56]

In other words, the ethical code prevented physicians from taking salaried positions with lay organizations or splitting professional fees with lay organizations.[57]

As one commentator noted:

> Through the development and enforcement of an ethical code, the AMA was able to organize regular physicians and distinguish them from less reputable practitioners. By procuring passage of licensing legislation, the regular medical profession began to limit competition and raise the quality of practitioners. With successes in educational reform, the AMA further controlled competition and advanced physicians' expertise. By the early twentieth century, the AMA brought public respect and greater financial reward to physicians and

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53. Chase-Lubitz, *supra* note 12, at 449.
54. *See id.* at 464-69.
55. *Id.* at 459 (quoting *In re* AMA, 94 F.T.C. 701, 1011 n.59).
56. *Id.* at 462 n.113.
57. *See id.* at 462-63.

established the regular medical profession's virtual control over medical care.[58]

As noted above, the AMA, the state legislatures, and the courts created and maintained the prohibition on the corporate practice of medicine. The federal government was not concerned about the manner in which medical services were organized and delivered until the 1960s. Prior to that point, the federal government was not significantly involved in health care, either through the licensing of providers or through regulation.[59] This changed in 1965 with the introduction of the Medicare program.[60] With the introduction of the Medicare program, the federal government became significantly involved in health care as the major purchaser of health care services.[61]

As a major purchaser of health services, the federal government quickly became concerned about the cost of those services. This concern signaled the beginning of the end of the prohibition on the corporate practice of medicine. Two federal responses to health care cost containment undermined the continuing viability of the prohibition on the corporate practice of medicine. These were actions by the Federal Trade Commission (FTC) in its enforcement of antitrust laws and the enactment of the Federal HMO Act.

The FTC determined that the AMA's promulgation of ethical opinions concerning the corporate practice of medicine constituted anticompetitive conduct by the profession.[62] It enjoined the AMA from the publication and dissemination of ethical codes that proscribed

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58. *Id.* at 455 (footnote omitted).

59. Federal involvement in health care expenditures began in the 1930s with the introduction of legislation to provide medical services for recipients of the Federal Emergency Relief Administration. Title V of the Social Security Act of 1935 provided grants to states, for maternal and child health programs, and Title VI authorized grants to assist state and other political subdivisions "in establishing and maintaining adequate public health services." WILLIAM L. KISSICK, MEDICINE'S DILEMMAS 77 (1994). The Hospital Survey and Construction Act of 1946, known as the Hill-Burton program, directed funds towards the development of hospitals, public health centers, and other facilities. *See id.* at 78-79. The government supported research via the establishment of the National Institute of Health and the National Cancer Institute in 1937, the National Heart Institute in 1948, and the National Institute of Mental Health in 1949. *See id.* at 78. In 1956, Congress authorized support for the training of public health personnel for programs established under Title VI of the Social Security Act. *See id.* at 79.

60. *See* Title XVII of the Social Security Act, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended at 42 U.S.C. §§1395-96).

61. With the advent of Medicare and Medicaid, federal expenditures for health care rose from $9.5 billion in 1965 to $41.5 billion in 1975. *See* Sven Steinmo & Jon Watts, *Its The Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America*, 20 J. HEALTH POL. POL'Y AND L. 329, 357 n.20 (1995). By 1993, this figure had risen to $281 billion, or 32% of the total $884 billion spent on health care. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 31.

62. *See In re* AMA, 94 F.T.C. 701 (1979).

physicians from entering into various types of financial arrangements.[63] This would remove an effective method for enforcing the prohibition on the corporate practice of medicine.[64]

The AMA's ethical codes were an effective means of enforcing the prohibition on the corporate practice of medicine.[65] However, the ethical codes never had the force of law. Notwithstanding the FTC action, legislation and judicial opinions still remained as obstacles to the employment of physicians by corporations.[66] In 1973, Congress removed some of these obstacles by passing the Federal HMO Act.[67] The purpose of the Act was to promote the development of HMOs as a means for controlling health care costs and increasing access to health care.[68] The legislation preempts state laws requiring that all of the board of directors of an HMO be physicians.[69]

These two federal actions hastened the demise of the corporate practice doctrine.[70] Legal commentators have applauded this action because the doctrine stood as an obstacle to the development of innovative health care delivery systems needed to control health care costs and increase access to care.[71] Unfortunately, dismantling the doctrine also contributed to the development of subtle (Machiavellian?) disruptions in the physician-patient relationship.

IV. RISK SHARING: A HEALTH CARE FINANCING INNOVATION

As cost containment came to the foreground as a predominant issue in health care, innovative strategies arose for dealing with the cost of health care.[72] Physicians were key actors in the health care delivery system and were identified as the prime actors in the decision to

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63. *See id.*

64. *See* Chase-Lubitz, *supra* note 12, at 458-64 (relating to the role of the American Medical Association (AMA) ethical pronouncements of enforcement of corporate practice doctrine).

65. *See id.*

66. *See id.* at 464-67 (indicating role of state licensing laws statutes and judicial interpretation of those laws.)

67. Health Maintenance Organization Act of 1973, Pub. L. No. 93-100 (codified as amended at 42 U.S.C. § 300e. (1996)).

68. *See* S. REP. 93-1279 (1973), *reprinted in* 1973 U.S.C.C.A.N 3033.

69. 42 U.S.C. § 300e-10(a)(1)(B) (1996).

70. *See* Chase-Lubitz, *supra* note 12, at 478 ("[T]he recent abolition of these ethical restrictions [by the Federal Trade Commission (FTC)] greatly weakens the foundation upon which the corporate practice of medicine doctrine was built.") and 482 ("[T]he HMO legislation implicitly preempts the common law prohibition . . . and is a sweeping federal policy statement in favor of a corporate-based competitive health market. The legislation eschews a medical economy dominated by independent, fee-for-service practitioners.").

71. *See id.* at 488.

72. *See infra* notes 84-117 and accompanying text.

consume health care resources.[73] Therefore, many of the cost containment strategies were aimed at controlling physicians' behavior.[74] As the payers sought more effective methods to contain costs, they adopted strategies that became more and more intrusive into the physician-patient relationship. This moved the physician-patient relationship further away from the relationship idealized by courts that espoused enforcement of the prohibition on the corporate practice of medicine. These courts had envisioned that the physician-patient relationship was a fiduciary relationship which should not be encumbered by lay profit motives. Eventually, the payers achieved the ultimate coup by realigning the physicians' financial interest to coincide with the payers' financial interests. The payers accomplished this fundamental realignment by risk sharing.[75] Risk sharing involves shifting some of the cost of providing health care from the payers to the physicians.[76]

The cost of medical services increased at an alarming rate between 1970 through the early 1990s.[77] Medical inflation generally outstripped the general inflation rate and health care consumed a greater and greater portion of the gross national product.[78] One theory explaining

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73. *See* Lu, *supra* note 19, at 528; *see also infra* notes 82-117 and accompanying text.

74. *See infra* notes 82-117 and accompanying text.

75. *See* RODWIN, *supra* note 26, at 139-40. Rodwin notes:

> Most HMOs . . . use payment incentives to tie the interests of physicians to the financial goals of the organization. They frequently make physicians—particularly primary care physicians—bear part of the financial risk for providing services, so that their incomes decrease as the cost of treating patients rises.

Id.

76. *See id.*

77. Between 1970 and 1994 the total expenditures for health care rose from $73.2 billion to $949.4 billion. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 239, tbl.114. This represents more than a twelve-fold increase. By comparison, the increase for total gross domestic product was only seven-fold from $1,035.6 billion to $6,931.3 billion. *See id.*

78. The average general inflation index and medical inflation index between 1970 and 1994 was:

	All Items	Medical Care
1970-1975	6.8	6.9
1975-1980	8.9	9.5
1980-1985	5.5	8.7
1985-1990	4.0	7.5
1990-1995	3.1	6.3

Id. at 241, tbl.116.

The percentage of the gross national product (GNP) represented by expenditures for medical services

the persistence of increasing health care expenditures was that it resulted from the system for financing health care. Health insurance reimbursed health care providers for services on the basis of retrospective cost.[79] After the provision of the services, the provider would submit a bill to the insurance company, and if the bill did not appear to be out of line with industry norms, the insurance company paid the bill. There was no requirement for advance pricing or advance approval for most medical procedures, including high cost in-patient hospital services.[80] In this system, the physician directed the consumption of health care resources without external limitations. The patient was not concerned about the costs because the insurer made the payments. The insurer was not concerned with the cost because it would be able to pass the cost along in the form of higher premiums paid by the employers. Therefore, the bills were passed along through the system and no one had an interest in containing health care delivery costs.[81]

The physician reigned supreme in this system. The physician alone had the expertise necessary to determine what medical treatment a patient required. It was, therefore, the physicians who directed the consumption of health care resources.[82] The physicians' financial interest under the fee-for-service system was aligned with more, rather than less, consumption of medical resources.[83] The more services that the physician determined the patient needed, the more the patient received and the more the physician was paid.

Recognizing the physicians' role in health care consumption decisions, the insurance industry and the payers adopted cost containment strategies aimed at the physicians' decision-making. These strategies, known as managed care, included utilization review—requirements that the physicians desiring to conduct a test or provide a procedure needed to obtain preapproval from the payer.[84] Utilization

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rose from 7.1% in 1970 to 13.7% in 1994. *Id.* at 241, tbl.114. By comparison, in 1993 when U.S. expenditures for medical care represented 13.6% of the GNP, the percentage of the GNP spent on medical care in other developed countries was as follows: Canada (10.2%), France (9.8%), Germany (8.6%), Japan (7.3%), and the United Kingdom (7.1%). *See id.* at 240, tbl.115. It is also clear that expenditures per capita in the U.S. exceed those of other nations. *See id.* In 1993 the U.S. spent $3,331 per capita, while other developed countries' spending was as follows: Canada ($1,971), France ($1,835), Germany ($1,815), Japan ($1,495), United Kingdom ($1,213). *See id.*

79. *See* Randall, *supra* note 4, at 14-15.

80. *See generally id.* at 15-16.

81. *See id.* at 15 & n.50; *see also* Gregg Easterbrook, *The Revolution in Medicine Care,* NEWSWEEK, Jan. 26, 1987, at 43 (describing the "pass along" feature of health care financing).

82. *See* Lu, *supra* note 19, at 528.

83. *See* Randall, *supra* note 4, at 15; Bodenheimer, *supra* note 20, at 972.

84. *See* Mary R. Kohler, *When the Whole Exceeds the Sum of Its Parts: Why Existing Utilization Management Practices Don't Measure Up,* 53 U. PITT. L. REV. 1061, 1062-63 (1992).

review included preadmission review or precertification for inpatient hospital services or diagnostic tests,[85] concurrent review,[86] and required second opinion for elective surgical procedures[87] and gatekeepers.[88]

In addition, insurers and payers also introduced alternative arrangements for health care delivery. The most traditional was the HMO.[89] HMOs are distinguished from traditional insurance in that they represent a combination of the insurance function with the service provider function. HMOs collect premiums and arrange for the provision of health care services by employing or contracting with physicians.[90] HMOs attempt to address the cost of health care by: (1) emphasizing preventative care, (2) extensive utilization management, and (3) alternative fee structures with physicians.[91] An additional form of managed care is the preferred provider organization (PPO).[92] Under a PPO arrangement, a select group of physicians contracts to provide medical services to patients at discounted fees.[93] The PPO also typically combines some form of utilization management in order to control the consumption of health care resources.[94]

Utilization management proved to be an unsatisfactory method of controlling health care expenditures. It added an additional layer of bureaucracy to the health care delivery system.[95] It did not actually save any money.[96] Also, physicians purportedly hated utilization review

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85. *See id.* at 1070. Preadmission certification occurs prior to a patient's admission to the hospital for nonemergency treatment.

86. *See id.* Concurrent review occurs while the patient is still in the hospital. Under concurrent review, the payer determines the patient's need for continuing hospital in-patient services.

87. *See* Randall, *supra* note 4, at 28.

88. *See id.*

89. *See* Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 291 (1995). In this article, the authors note that the term "HMO" was coined in the 1970s but the concept was created in the 1920s. They also describe the establishment of Kaiser-Permenente in the mid-1930s. *See id.* Kaiser was established to provide for the health care needs of Kaiser employees who worked on the Grande Coulee Dam in Washington State. *See id.* As of 1996, Kaiser was still in operation and listed as one of the nation's 43 largest HMOs with membership of approximately 3.5 million in Hawaii, California, Georgia, Ohio, the mid-Atlantic, and the Northwest. *See* Ellyn Spragins, *Does Your HMO Stack Up?*, NEWSWEEK, June 24, 1996, at 61-62 (survey rating 43 of America's largest HMOs). Kaiser represents a traditional HMO in that it both owns hospitals and employs the physicians who serve its patients. *See* RODWIN, *supra* note 26, at 138 ("The first HMOs, now called *staff model HMOs*, owned medical care facilities and employed a group of physicians on salary.").

90. *See* Randall, *supra* note 4, at 20 & n.73.

91. *See* Bearden & Maedgen, *supra* note 89, at 294-95.

92. *See* Bodenheimer, *supra* note 20, at 971.

93. *See id.*

94. *See id.*

95. *See id.*

96. *See, e.g.*, Kohler, *supra* note 84, at 1103 (indicating that although some researchers report a potential saving of six percent per employee, other researchers criticize the methodologies of such studies); *see also Are HMOs the Answer?*, CONSUMER REPORTS, Aug. 1992, at 519, 520 (noting that calculation of cost

because it represented an intrusion into their professional autonomy.[97] Because of these concerns, utilization review has been criticized as an ineffective means to limit medically unnecessary services.[98]

In order to effectively address the cost problem, the payers needed to co-opt physicians.[99] The payers could achieve this by shifting some of the financial risk for the cost of health care onto the physicians. Because physicians made the decisions regarding consumption of health care services, if the decision to consume would have a negative financial consequence for the physician, perhaps the physician would consume fewer services by ordering fewer diagnostic tests and not referring the patient for in-patient services.[100] As one commentator observes:

> [T]he control strategy that will work best is to influence physicians to change their practice styles, to acquire a new treatment philosophy, through a motivational force that orients them toward a more conservative end of the acceptable range of variation in medical practice. . . . The most effective motivational force is likely to be financial incentive. If fee-for-service or cost-based reimbursement is seen as the source of health care's excess, reversing financial incentives to reward physicians for less rather than more treatment can be expected to change practice styles across the board.[101]

Risk sharing appears in two forms: (1) payment on the basis of capitation,[102] and (2) fee withholding.[103] Payers may use these forms of risk sharing separately or in combination with one another.[104] Under capitation reimbursement, in lieu of receiving a payment for each encounter with a patient, the physician receives a flat monthly payment per each patient assigned to the physician's care.[105] The payment is the

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savings from utilization may be overstated due to method of calculating the savings and that administrative costs associated with utilization review may further detract from the savings); THOMAS M. BURTON, *Second Opinion: Firms That Promise Lower Medical Bills May Increase Them*, WALL ST. J., July 28, 1992, at A1 (noting that review by Inspector General of the U.S. Health & Human Services Department concluded that the government had paid $13.3 million to utilization review companies to save $1.4 million in possibly unnecessary surgery).

97. *See* Kohler, *supra* note 84, at 1077 ("Physicians are generally the most adamant opponents of concurrent review. They argue that it interferes with their clinical decisions, and places them in a tenuous position.").

98. *See generally id.*

99. *See* Hall, *Institutional Control*, *supra* note 12, at 482-83.

100. *See id.*

101. *Id.* Hall notes that in Great Britain, physicians adopt a far less aggressive style of medicine due to severe resource constraints. *See id.*

102. *See* Randall, *supra* note 4, at 30.

103. *See id.*

104. *See, e.g.*, Hillman, *supra* note 23, at 1745 (noting that 67% of surveyed HMOs combined capitation and withholding).

105. *See* MARK V. PAULEY ET AL., PAYING PHYSICIANS: OPTIONS FOR CONTROLLING COST,

same regardless of how often or whether the patient utilizes the physician's services during the month. Therefore, the physician is at risk that patients' demand for services may exceed the fee-for-service value of the services. The demand may require the physician to expand the physician's office hours or add additional staff.[106]

Under fee withholding, the payer withholds a percentage of the physician's compensation (either the fee for services or the capitation payments). The payer distributes the withheld fees to the physician at the end of a specified period of time if the physician's performance meets certain criteria which the payer establishes. The performance criteria are typically related to the costs for expensive medical treatment, in particular, expenditures for referrals to specialists and expenditures for in-patient hospital treatment.[107]

For example, the payer may withhold twenty percent of the physician's fees earned during a month. The payer will allocate the withheld fees to a referral- and hospital-services risk pool.[108] The payer allocates funds for referral services and hospital services in accordance with a budget for such services.[109] The payer determines the risk pool budgets by using actuarial data that indicate the average cost for such services.[110] The payer pays for such services from the referral- and hospital-services risk pool.[111] If the payer's actual expenditures exceed the budget for such services, the payer applies the physician's withheld fees to the payment of the referral services and in-patient hospital services.[112] The physicians forfeit the withheld fees.[113] If the payer actually expends less than the budgeted amounts, the physicians will be entitled to recoup some or all of their withheld fees.[114] In effect, the fee withholding places a designated percentage of the physician's income at risk for health care services that are not provided by the physician. The more services the physicians utilize, the less likely the physicians will recoup the withheld fees.

Risk sharing has become increasingly popular as a health care cost-containment mechanism.[115] It is the financing mechanism of choice in

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VOLUME, AND INTENSITY OF SERVICES 101 (1992).

106. *See* Bodenheimer, *supra* note 20, at 973 (describing how under a system of capitation in which physicians are only responsible for their own services, it is only physicians' time that is at risk).

107. *See, e.g.*, Hillman, *supra* note 23, at 1744.

108. *See id.*

109. *See id.*

110. *See id.*

111. *See id.*

112. *See id.*

113. *See id.*

114. *See id.*

115. *See, e.g.*, Alan L. Hillman, et al., *HMO Managers views on Financial Incentives & Quality*, 10 HEALTH

so-called mature managed care markets.[116] Although originally a creature of the private sector, risk sharing has also begun to take hold in the federal programs, Medicare and Medicaid, albeit in an indirect fashion.[117]

Risk sharing would not have withstood a challenge based on the prohibition on the corporate practice of medicine. Risk sharing violates the corporate practice doctrine's prohibition on physicians sharing their fees with lay persons. Under capitation, the physician no longer sets a fee. The managed care organization establishes the fee. Under withholding, the managed care entity retains physicians' fees for application against its own costs. These arrangements would violate the corporate practice doctrine on their face. Further, it would not be difficult for a court to articulate how these practices also violate the principles inherent in the corporate practice doctrine—division of loyalty, exploitation of medicine, and physician autonomy.[118]

AFF. 207, 208 (1991) ("Approximately one-half of HMOs pay primary care physicians by capitation . . . 60 percent . . . use a withhold account."); *see also* RODWIN, *supra* note 26, at 140 ("Risk sharing is the norm in HMOs.").

116. *See, e.g.*, The Advisory Board, CAPITATION I: THE NEW AMERICAN MEDICINE 38 (on file with the *University of Cincinnati Law Review*) ("Capitation is largely a West Coast phenomenon."). The West Coast (California, Oregon, Washington and Arizona) has been characterized as an area with high penetration of managed care. *See* Press Release from KPMG Peat Marwick, *Managed Care Study* (June 1, 1995) (on file with the *University of Cincinnati Law Review*) (describing Los Angeles and San Francisco, California and Portland, Oregon as cities with high penetration of managed care).

117. Medicare and Medicaid do not directly enter into risk-sharing arrangements with physicians. However, under the two programs, the federal government has authorized Medicare and Medicaid HMOs. Under Medicaid, states have pursued managed care approaches for Medicaid recipients pursuant to waivers under §§ 1115 and 1915 of Title XIX of the Social Security Act. *See* William A. Rivera, *A Future for Medicaid Managed Care: The Lessons of California's San Mateo County*, 7 STAN. L. & POL'Y REV. 105, 111-12 (1995-96). The number of Medicaid recipients enrolled in managed care plans increased to eight million in 1994, covering twenty-four percent of the Medicaid eligible population. *See* Prospective Payment Assessment Commission, Report and Recommendations to Congress, 60 Fed. Reg. 29,384, 29,402 (1995) [hereinafter Prospective Payment].

Under Medicare, § 1876 of Title XVIII of the Social Security Act authorizes the provision of services for Medicare beneficiaries by managed care entities. *See* Health Care Financing Administration, Health and Human Services, 61 Fed. Reg. 69,034, 69,034 (1996). Enrollment of Medicare beneficiaries in Medicare HMOs rose from three percent of the total Medicare population in 1988 to almost five percent in 1994. *See* Prospective Payment, *supra*, at 29,410.

Under either Medicaid or Medicare, HMOs may assume risk by receiving compensation based on capitation payments. *See* Health Care Financing Administration, 61 Fed. Reg. at 69,035. These entities must have procedures in place to control the cost of health services, including risk sharing or financial incentives with providers. *See* 42 C.F.R. 417.103(b) (1996).

118. *See, e.g.*, Chase-Lubitz, *supra* note 12, at 481 ("[I]nherent in the HMO structure is the risk that a physician's loyalty will be divided between employer and patient, a risk no less evident in the HMO structure than in the corporate structures held illegal under the corporate practice doctrine decades earlier."); *see also* Sheva J. Sanders, *Regulating Managed Care Plans Under Current Law: A Radical Reversion To Established Doctrine*, 20 HOFSTRA L. REV. 73, 86 (1991).

> A physician's . . . participation in an arrangement whereby she is offered financial incentives to limit access to health care services, at best, raises legitimate concerns about her ability to

V. THE DANGER AND DISHONESTY OF RISK SHARING

An analysis of risk sharing indicates that it is either dangerous because it influences physician behavior, or dishonest because it creates a hidden subsidy for the private insurance industry by allowing the industry to export part of its costs to physicians. Risk sharing could significantly alter the physician-patient relationship in very detrimental ways.[119] It could achieve this by destroying the traditional alignment between patients' and physicians' interests. This could cause harm to patients who are injured as a result of decisions influenced by financial concerns. The potential for such problems is more readily apparent in a system of individualized risk sharing in which one physician is required to assume the risk for that physician's own patients. However, it is unlikely that individualized risk sharing will prevail. The more direct the relationship between a negative financial inducement and damage to a patient, the more likely is the prospect for liability.[120] Payers tend to adopt pooled risk-sharing arrangements in which groups of physicians will assume the risk for patient care.[121]

Pooled risk sharing may or may not alter individual physician conduct. Pooled risk sharing does, however, allow payers to shift the cost of health care onto physicians. In pooled risk-sharing systems physicians are allowed to exercise their best professional judgment, but the physicians are, in effect, required to pay for exercising that judgment. The cause and effect relationship between the individual physician's decision and the negative financial consequences for the physician is ameliorated, however, because the pooled risk-sharing arrangement rewards and punishes aggregate behavior, not individual behavior. Pooled forms of risk sharing are merely a dishonest means to export the cost of financing health care needs onto the physicians. It

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> think only of her patients interests and, at worst, means that she has agreed to allow a third party to exercise control and direction over her professional judgment.

Id.

119. *See, e.g.*, RODWIN, *supra* note 26, at 140 ("Such incentives encourage physicians to ask themselves 'How much will this cost me?' before providing or recommending medical services. As a result, physicians may recommend too little medical care.").

120. *See infra* notes 216-28 and accompanying text. An analysis of the cases in which plaintiffs have sued managed care entities and physicians have alleged that the financial incentives imposed on physicians contributed to the patient's harm, indicates that the courts were swayed by the lack of evidence of a direct causal relationship when they decided to rule against the plaintiff. In the one case in which such a causal relationship was clear, the court cleared the way for the plaintiff to go to trial. For a description of facts in *Bush v. Dake*, see *supra* note 2.

121. *See infra* notes 130-34 and accompanying text.

also allows payers to relieve themselves of the potential liability associated with denying care in utilization review disputes.[122]

An example of individualized risk sharing would be an arrangement between a payer and an individual primary care physician pursuant to which the physician receives capitation payments and also has a percentage of such capitation payments withheld by the payer for the payer to apply against the payer's expenditures for that physician's referrals to specialists or admission of patients for in-patient hospital care. Under such a system, there would be a direct financial consequence to the physician each time the physician referred a patient to a specialist or admitted a patient to a hospital. At the end of the year, if the physician's referrals and hospital admissions caused the payer's expenditures to exceed the budget that the payer established for the physician, the physician would forfeit the withheld fees.[123]

Individualized risk sharing alters the traditional alignment between the physician's financial interests and the patient's best interests.[124] Under the traditional fee-for-service payment system, in a marginal case, if the issue was whether to conduct an additional test or provide a particular procedure, the payment structure arguably aligned the physician's interest with that of the patient. There was no cost to the patient for conducting the additional test or recommending the additional procedure and there was no financial disadvantage for the physician. Under an individualized risk-sharing system, the physician's fiduciary duty to the patient may be antagonistic to the physician's financial interests because referring the patient for specialized services has a financial consequence for the physician.

Another important aspect of this individualized risk sharing is that it shifts the responsibility for rationing health care services onto physicians.[125] This means that the payers can effectively remove

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122. *See infra* notes 139-41 and accompanying text.

123. *See, e.g.*, Hall, *Institutional Control*, *supra* note 12, at 484.

> There are a number of variations on this theme. For example, one IPA [independent practice association] established an account for each physician consisting of a percentage of the premiums paid by that physicians patients. Each physician received half of any surplus . . . and contributed half of any deficit, up to ten percent of the . . . [physician's] HMO reserve.

Id.

124. *See generally* RODWIN, *supra* note 26.

125. *See* Hall, *supra* note 21, at 758 (examining ethical issues that arise when physicians are induced to engage in rationing through financial incentive arrangements); *see also* Alexander Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 748-49 (noting that "reimbursement plans that place physicians . . . at financial risk are intended to ally physicians with society's new position that many medical interventions are not cost-beneficial and ought to be avoided").

themselves from responsibility and liability for health care rationing while enjoying the cost savings resulting from physicians' decisions.[126] In effect, while the physician absorbs part of the financial costs of health care, the physician also absorbs the psychic cost of rationing. As explained by Alan Hillman:

> [I]n the absence of a social mandate that specifies how resources should be used, physicians should not be required to translate what society is "telling us in many different ways" to the point of making allocation decisions at the level of the individual doctor-patient interaction. Furthermore, these decisions certainly should not be made by virtue of what is in the provider's best financial interest.[127]

In this sense, individualized risk sharing allows payers to export some of the social cost of financing health care—making hard allocation decisions.

Individualized risk sharing is a very convenient procedure for containing health care costs. It is also very dangerous. It relies on the cause and effect relationship between a physician's actions and the financial impact of those actions in order to conscript the physician to the task of cost containment, the hope being that the physician will not order medically unnecessary services because it is not in the physician's financial interest.

At this point, the danger of risk sharing to patients is apparently largely speculative. Despite growing attention in the popular media,[128] empirical research has not revealed any correlation between risk-sharing arrangements and any decline in quality of care.[129] This may be attributable to the fact that the typical risk-sharing arrangement is not designed to produce a direct causal relationship between an individual

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126. *See* McGraw, *supra* note 7, at 1836 ("The clandestine character of these incentives also inhibits the ability to link an adverse outcome to the use of financial incentive arrangements.").

127. Alan L. Hillman, *Correspondence, Gatekeepers and Cost-Containers in HMOs*, 318 NEW ENG. J. MED. 1699, 1700 (1988).

128. *See, e.g.*, Haney & Bayles, *supra* note 2, at 3. The authors related the following stories: a patient with kidney failure who suffered cardiac arrest after his HMO primary care physician refused to refer him to a specialist, a patient not referred for services that would have detected cervical cancer, a patient with history of manic depression taken off medication by his HMO physician, a patient with lump in breast told by HMO physician not to worry about it and subsequently found to have spreading cancer. *See also* Olmos, *supra* note 8, at A1 (relating lawsuit over death of colon cancer victim based on HMO physician's delay in conducting tests).

129. Mary Ann Bobinski, *supra* note 25, at 307-09. On the other hand, surveys do reveal a correlation between patient satisfaction with the services received and the compensation arrangement between the physician and insurer. *Consumer Reports* conducted a survey that found a significant relationship between member satisfaction and the way primary care doctors in an HMO were paid. *See Are HMOs the Answer?*, *supra* note 96, at 519. HMOs that compensated physicians on a fee-for-service basis have tended to rate higher in member satisfaction than HMOs that either capitated physicians' payments or subjected physicians to fee withholds. *See id.* at 523.

physician's actions and a negative financial consequence to that physician. Risk-sharing systems are typically designed to punish and reward the aggregate conduct of a group of physicians through pooled risk-sharing arrangements.[130]

Insurers establish pooled risk-sharing arrangements through two general methods. Under the first method, the payer may enter into an agreement with an organized group of physicians, either a group practice or an independent practice association.[131] Under this system, the group may be subject to a risk-sharing arrangement, for example, the group may accept capitation payments and be responsible for compensating the individual physicians from the capitation payments.[132] Under the second method, the payer may pool risk by entering into agreements with individual physicians, but placing withheld fees at risk for the performance of the entire group of physicians.[133] For example, although the insurer enters into individual capitation agreements with physicians, it might withhold fees from the individual physicians and condition the return of such withheld fees based on the expenditures for referral to specialists and admissions to hospitals by all of the primary care physicians under contract with the managed care entity in a geographic region.[134]

Under either of the pooled risk-sharing arrangements, there is nothing that the individual physician can do to recoup the physician's withheld fees. Therefore, pooled risk-sharing arrangements arguably decrease the potential realignment of the individual physician's interests vis-à-vis the patient's interests and, theoretically, have less potential for harm.

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130. *See* Alan L. Hillman et al., *Contractual Arrangements between HMOs and Primary Care Physicians: Three-Tiered HMOs and Risk Pools*, 30 MEDICAL CARE 136 (1992). The authors attempt to refine the analysis of financial incentives paid to physicians. They note that previous studies failed to distinguish between two-tiered and three-tiered arrangements. *See id.* Under a two-tiered arrangement, the HMO contracts directly with the individual physicians. *See id.* Under a three-tiered arrangement, the HMO contracts with some middle tier entity which in turn contracts with the individual's physicians. *See id.* One point of this study is that the actual percentage of individual physicians actually compensated on the basis of capitation might be overstated because some of the capitation payments reported were actually being paid to a middle-tier entity. *See id.* at 141. For the purposes of risk sharing, it would be the middle-tier entity and not an individual physician who was engaged in risk sharing. *See id.* at 140. They note, "in three-tiered HMOs the intervening entities may change the contractual arrangements so that the financial incentives and other obligations do not directly impact the physicians." *Id.* at 137. Approximately 35% of the HMOs that responded to the survey were three-tiered HMOs. *See id.* at 142 tbl.2. Further, in accordance with the survey, IPA risk pools only involve one physician in 15% of the cases. *See id.* at 144, 143 tbl.6.

131. *See id.* at 138 (noting that the HMO contract may be with the medical staff of a hospital, a physician group, or the entity formed for payment purposes).

132. *See id.* at 140.

133. HMOs that contract directly with individual physicians are referred to as having two tiers. *See id.* at 137. In such two-tiered systems, 44% involved risk pools that cover all physicians in the HMO. *See id.* at 144 tbl.6. Only 19% of such systems engage in risk pooling on an individual basis. *See id.*

134. *See id.* at 140.

However, this is only true to the extent that the group of physicians do not have power to enforce conduct in order to meet group goals and to the extent that risk sharing does not influence the group's exercise of power over the individual physician. Depending on the degree of power that the group exercises over the individual, the group can establish the same performance criteria that the payer uses and thereby subject individual physicians to the same pressures as individualized risk-sharing arrangements.[135]

To the extent that the group of physicians covered by a pooled risk-sharing arrangement has no control over the conduct of individual physicians in the pool, pooled risk sharing is merely a dishonest means to require physicians to subsidize part of the insurance industry's cost of doing business. To the extent that the law allows this to continue, the law provides a hidden subsidy for the private health insurance field. This is the beauty of pooled risk-sharing arrangements—the system is designed so that the relationship between the physician's conduct and the system is so tenuous that it escapes scrutiny;[136] yet, the system effectively allows the insurers to export part of their costs to the physicians.

Another attraction of risk sharing for payers is that it potentially renders the conflicts inherent in utilization review moot. Utilization review is criticized for being ineffective and cumbersome.[137] However, utilization review is also dangerous for payers because it is explicit. Under utilization review, the physician is not required to abandon the physician's traditional role. Utilization review merely means that in order to obtain what the physician believes is in the patient's best interest, the physician might need to become an advocate for the patient against the payer's utilization review program.[138] This creates a potential ground of liability for the payer who denies care to a patient based on a utilization review decision. In *Wickline v. State*[139] and *Wilson*

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135. *See id.* at 146 (noting that managerial control affected by peer pressure and group norms might cause individual members to change behavior, even though the degree of risk on the individual physician might be very small).

136. *See infra* notes 216-28 and accompanying text.

137. *See supra* notes 95-98 and accompanying text.

138. *See, e.g.*, Robert A. Berenson, *A Physician's Reflections*, 19 HASTINGS CENTER REPORTS 13 (Jan.-Feb., 1989) (noting that utilization review relies on the physician's willingness to become adversarial, rather than on the "merits" of the case, and that most physicians take responsibility for acting as an advocate very seriously).

139. 239 Cal. Rptr. 810 (Cal. Ct. App. 1986). In *Wickline*, the court dealt with the issue of whether a payer could be liable for injury to a patient resulting from the payer's decision to deny financing for the patient's medical care as requested by the patient's physician. *See id.* at 811. Ms. Wickline's doctor had requested an extension of eight days for her recovery from an operation on her leg. *See id.* at 813. The utilization reviewers for the Medi-Cal Program denied the request for eight additional days and granted

v. Blue Cross of Southern California,[140] California courts indicated that, in the appropriate circumstance, a payer's utilization review decision could serve as the basis for a cause of action.[141] To the extent that risk sharing could prevent salient disputes over medical necessity decisions, it tends to reduce the exposure to liability for payers. Individualized risk sharing potentially achieves this goal by introducing adverse financial consequences to the physician's decision to refer the patient to specialists or for in-patient hospital services. Pooled risk sharing potentially renders the issue moot for the payers. It does not matter to the payer if the payer has to pay for care if the payment ultimately comes out of the physician's own pocket anyway.

It is apparent that there is a great deal of care provided which is not medically necessary.[142] Therefore, there is a need to find a way to control the unfettered discretion to consume health care services. For some procedures, at least, standardized treatment protocols may be useful.[143] The health care system may be in need of some centralized

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a stay of only four days. *See id.* at 814. Ms. Wickline was discharged from the hospital at the end of four days and returned to her home. *See id.* at 815. She subsequently suffered complications which resulted in her leg being amputated. *See id.* at 811. She sued the Medi-Cal program, alleging that its utilization review decision had contributed to her injury. *See id.* The court dismissed the claim but did state that under the appropriate circumstances, a utilization review decision could serve as the basis of liability. *See id.* at 819-20.

140. 271 Cal. Rptr. 876 (Cal. Ct. App. 1990). In this case, the court revisited the issue of liability for utilization review. *See id.* at 880-81. Wilson was diagnosed as suffering from clinical depression, a condition for which his physician recommended inpatient psychiatric care. *See id.* at 877. The utilization reviewer determined that such care was not necessary and indicated that Wilson's insurance would not pay for such care. *See id.* at 877-78, 882. Mr. Wilson was discharged and subsequently committed suicide. *See id.* at 878. The court determined that the patient's estate had a cause of action against the utilization reviewer. *See id.* at 878, 883, 884-85.

141. *See id.* at 883; *see also Wickline*, 239 Cal. Rptr. at 819.

> Third party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.

Id.

142. *See Wasted Health Care Dollars*, CONSUMER REP., July 1992, at 435, 436-37.

> Many researchers have now attempted to qualify the rate at which specific procedures are used unnecessarily. Twenty percent represents a rough average of the rates found in major studies, and is a figure that several leading researchers in this field told us was a good approximation for the rate of unnecessary care.
>
> Twenty percent also seems to be a conservative estimate of the rate of unnecessary hospital days, even though changes in Medicare and private-insurance policies make it difficult to estimate that number precisely.

Id.

143. *See* Hall, *Institutional Control*, *supra* note 12, at 478-79.

> Treatment protocols . . . serve some useful purpose simply as a checklist that forces physicians to think more carefully about their treatment decisions. By setting a baseline to which physicians must refer in formulating their treatment plan, protocols may help revise and formalize the informal heuristics that are central to physicians' judgmental thought

authority that will gather such information and determine the manner in which the information is used.[144] However, this process should be salient, explicit, and subject to accountability. Utilization review, despite any of its perceived shortcomings, is a more honest, open, and accountable means to achieve this goal. Despite the complaints about utilization review, it has one overriding benefit—the process is notoriously open. The process openly pits the physician and the patient against the utilization review organization. There is nothing secretive about the process.[145]

Cost containment that is achieved by risk sharing is the exact opposite of utilization review. Instead of being open and notorious, it is secretive and subterranean. The disputes over care are not salient, they are internal and fought out within the conscience of the individual physician at the point of delivery. They may even be subconscious, operating under the surface of the provider's attempt to exercise professional judgment. There is no adversarial fleshing out of the decision.

VI. CORPORATE PRACTICE DOCTRINE AS A RESPONSE TO RISK SHARING

Policy makers and commentators condone risk sharing as an effective strategy in a program to contain health care costs.[146] However, risk sharing evokes the same concerns that prompted courts and legislatures to adopt the prohibition on the corporate practice of medicine. Risk sharing has the potential for corrupting medical judgment to the detriment of quality of health care. In fact, risk sharing may be more vulnerable to charges of conflict of interest than the typical arrangements that were the concern of the corporate practice doctrine. Whether a physician was on a salary or not, or shared revenues with a lay person probably did not create as much of a temptation as arrangements whereby percentages of the physician's income are withheld toward the attainment of profit and loss goals.

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processes.

Id. (footnote omitted).

144. The need for a centralized data gathering entity is supported by the concept of "small area variation." *Wasted Health Care Dollars*, CONSUMER REP., *supra* note 142, at 441. This concept was developed by John Wennberg of Dartmouth University to describe the phenomenon of variation between communities with respect to physicians' medical decisions. *See id.* Because physicians practice in local areas, they tend to take their cues from the physicians practicing around them. *See id.* This leads to variations from community to community. *See id.*

145. *See* Berenson, *supra* note 138, at 13.

146. *See, e.g.*, Hall, *Institutional Control*, *supra* note 101, at 507-08.

Risk sharing blurs the distinctions between inherently antagonistic health care functions. It places physicians in the business of insurance.[147] Insurance involves accepting the risk of liability for expenses in exchange for a payment of premiums.[148] Capitation payments are insurance premiums that physicians accept in exchange for their agreement to accept the expenses associated with their patients' needs for medical services.[149] The fact that the risk is internal is of little comfort. If physicians find that the demand for their time is beyond what the capitation payments allow them to provide, what happens? Along the same lines, fee withholding represents a physician's agreement to place certain assets at risk for medical expenditures.[150] This is the same as an insurance company setting aside reserves to meet expenditures. One commentator has noted:

> Risk-sharing capitation relationships implicate the same concerns as traditional insurance relationships. Like traditional insurers, providers can minimize their costs by denying legitimate claims. However, unlike traditional insurers, providers are capable of controlling whether many of the claims are generated; by denying access to care for which the provider is at risk, the cost is avoided.[151]

The difference is that activities by insurance companies are heavily regulated,[152] while physician insurance activities are not. Another difference is that insurance companies have access to the actuarial data necessary to set capitation rates and establish risk-pool budgets.[153] This allows them to attempt to manipulate their exposure to loss. Physicians

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147. *See* Sanders, *supra* note 118, at 109.

148. *See id.*

149. *See id.* at 110.

150. *See, e.g.*, Hillman, *supra* note 23, at 1744 (discussing typical withhold arrangement).

151. Sanders, *supra* note 118, at 112.

152. FURROW ET AL., *supra* note 2, at 207.

> Private health insurance is extensively regulated in the United States. Traditionally, insurance regulation has been the business of the states. . . .
>
> State regulations attempt to assure the solvency of health insurance by prescribing capital and financial reserve requirements. They attempt to protect consumers by requiring disclosure of contract information, standardized printing of terms of coverage, insurance company bonding and auditing. Some states review and approve the rates charged by some insurers to some insureds (e.g. Blue Cross individual policy rates). . . . State laws often require private insurers to provide certain benefits, to pay for the services of certain providers, or to make coverage available to certain persons. State regulations also address coordination of benefits in situations where more than one family member is covered by more than one insurer.

Id.

153. *See, e.g.*, Michael Kraten & R. Michael Yesh, *Health Care Organizations—The Business Implications of Capitation Revenue Methodologies*, 14 AM. BANKR. INST. J. 15, 15 (1995) (noting the need for analysis of historical costs by demographic group in order to set capitation rates).

do not typically have access to such data and must rely on the good faith of the insurance companies to set capitation rates and risk-pool budgets that reflect the insurance company's estimate of what care should be needed.[154] Without the protection of the corporate practice doctrine, physicians share risk—engage in the business of insurance—as unequal partners with insurance companies.

The insurance industry is also covered by laws that protect the patient in the event of the insurer's insolvency. Insurance guaranty associations provided for under state laws require the association to fulfill an insolvent insurance company's obligations under its policies.[155] Although HMOs are generally not included in the guaranty associations, there are also state laws that prohibit physicians from pursuing patients for claims in the event of an HMO's insolvency.[156] The public does not have protection against physician insolvency which may result from its risk-sharing ventures. These concerns have influenced the National Association of Insurance Commissioners to take a closer look at the phenomenon of risk assumption by providers.[157] The disturbing trend is that state regulations appear to condone risk sharing as long as there is an insurance company or HMO in the arrangement.[158]

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154. *See id.* ("Uncertainties regarding actual costs . . . often lead health care organizations to accept insufficient capitation rates and incur significant financial risk."); *see also* Allison Overbay & Mark Hall, *Insurance Regulation of Providers That Bear Risk*, 22 AM. J.L. & MED. 361, 368 (1996) (noting that lack of actuarial expertise by provider groups may cause them to set capitation rates too low).

155. *See* Mark A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals and Trade Offs*, 32 HOUS. L. REV. 1319, 1373 n.262 (1996) (referring to guaranty association statutes in Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Maine, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, and North Dakota). These statutes provide for "guaranty associations" that fulfill the obligations of insolvent commercial insurers. *See id.* at 1373. In some jurisdictions, HMOs are also covered by guaranty associations. Karen O. Bowdre, *Guaranty Association Law in Alabama*, 20 CUMBERLAND L. REV. 321, 357 (1989-90) (noting establishment of HMO guaranty allocations in Alabama, Florida, and Illinois and inclusion of HMOs in life and health insurance guaranty associations in Utah and Wisconsin); *see also* National Association of Insurance Commissioners (NAIC), White Paper on Risk Bearing Entities (Dec. 1996), *reprinted in* 6 BNA HEALTH L. REP. 73, 95 (Jan. 9, 1997) [hereinafter NAIC White Paper] (noting that most states do not include HMOs and other managed care entities in guaranty association framework).

156. *See* Jay M. Howard, *The Aftermath of HMO Insolvency: Considerations for Providers*, 4 ANNALS HEALTH L. 87, 95 (1995) (noting requirement of NAIC Model HMO Act which provides that a "hold harmless" clause must be included in contract between HMO and contracting physician). Hold harmless clauses require physicians to contractually agree not to bill the patient in the event of the HMO's inability to pay. *See id.* at 96-97. The Model Act and variations thereon, have been adopted in over half of the states. *See* NAIC White Paper, *supra* note 155, at 82. The Federal HMO Act also requires that enrollees not become responsible for debts owed by the HMO. *See* Howard, *supra* at 93.

157. *See* NAIC White Paper, *supra* note 155, at 74. (noting that an underlying assumption is that all entities that assume health insurance risk should be subject to solvency and other appropriate consumer protection standards).

158. *See id.* at 85 ("The vast majority of states do not require a downstream contractor to obtain an

The message appears to be that the only way to curb health costs is if everyone shares in the financial risk. The private health insurance industry has engaged in financial risk shifting not only with physicians, but also with employers, hospitals, pharmaceutical companies, and patients. All of this risk sharing has proceeded with the acquiescence, and sometimes leadership, of the federal government.

Employers have accepted first dollar financial risk for health services by moving to self-insured plans[159] under the umbrella of the Employees Retirement and Income Security Act of 1974 (ERISA).[160] ERISA affords employers certain advantages such as preemption of state law causes of action and remedies.[161] ERISA also allows employers to avoid mandatory state health insurance requirements.[162] Through self-insurance, the insurance companies impose upon employers the obligation to engage in rationing health care.[163] Insurance companies have also required hospitals to accept per diem payments—another form of insurance premium.[164] Further, insurance companies have required patients to assume larger portions of the first dollar care by imposing higher deductibles and co-insurance requirements.[165] Insurers are also beginning to enter into risk-sharing arrangements with

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insurance license to accept insurance risk."). "Downstream" risk arrangements are contractual agreements through which physicians assume part of the insurance company's or HMO's risk. *Id.* Such downstream risk involves the mechanisms described in this Article: capitation and fee withholding. *See id.* at 79-80. Such arrangements admittedly involve the provider in the business of insurance; however, regulators have been inconsistent in their application of insurance requirements on such arrangements. *See id.*; *see also* Overbay & Hall, *supra* note 154, at 372 (noting that most states have opted to characterize downstream risk assumption as subcontracting, rather than the business of insurance, under the rationale that the main entity responsible for providing health care—the HMO—is already subject to strict regulation).

159. *See* Thomas Bodenheimer, *The Reconfiguration of U.S. Medicine*, 274 JAMA 85, 87 (1995) (noting that, in 1991, 40% of employees receiving employee-sponsored health benefits were in self-insured plans).

160. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 U.S.C. and 29 U.S.C.).

161. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44 (1987) (turning aside claim under Mississippi state law alleging bad faith denial of claim).

162. *See* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) (holding that state could impose mandated mental health coverage on insurers but could not require the same for self-funded employers).

163. *See, e.g.*, McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991) and Owens v. Storehouse, 984 F.2d 394 (11th Cir. 1993). In each of these cases, employers chose to limit coverage for employees suffering from AIDS in light of the threat to the fiscal integrity of their employee health benefit programs. The choices faced by such employers has been characterized as a "fundamental dilemma . . . one person's need for a huge amount of insurance coverage versus other group member's continued need for routine coverage." Maria O'Brien Hylton, *Insurance Risk Classification, After* McGann*: Managing Risk Efficiently in the Shadow of the ADA*, 47 BAYLOR L. REV. 59, 80 (1995). Self-insurance offers employers a flexible alternative to offering no health benefits at all. *See id.* at 77.

164. *See* Randall, *supra* note 4, at 31.

165. *See id.* at 17.

pharmaceutical companies.[166] Under the current regime, it appears that everyone is required to shoulder some financial risk for health care services.

Viewed in this context, risk sharing between insurers and physicians is just another example of the larger phenomenon. There is one fundamental difference, however. The other players are not decision makers operating in a fiduciary capacity. Hospitals do not decide whether to admit a patient—physicians do. Hospitals do not decide on the course of a patient's treatment—physicians do. Employers do not decide whether a patient needs a particular treatment—employers merely decide whether the employer sponsored health benefit package will cover the treatment. Employers do not establish treatment plans for patients.

Therefore, although risk sharing by physicians is consistent with the current environment in which it is assumed that everyone must assume some of the risk of health care expenditures in order to contain cost, there is something inherently problematic in physician risk sharing. By co-opting physicians to the insurance function, we remove an important actor in the preservation of the quality of health care—the advocate for treatment.[167]

If mechanisms were in place that prevented the payers from shifting the cost of doing business to the providers, several things might occur: (1) health insurance premiums would rise to a higher level thereby threatening additional consumers with the prospect of becoming uninsured, (2) there would be fewer insurance providers and perhaps more consolidation in health care financing, and (3) an honest effort to contain costs might occur. Each of these would be a benefit. To the extent that higher premiums threaten more individuals with loss of insurance coverage, this might increase political pressure for some type of universal health coverage.[168] To the extent that numbers of payers were forced out of the market, this would allow the remaining insurers

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166. *See, e.g.*, Alicia A. Barnett, *Strategies for the Future: Pharmaceutical Companies Emphasizing Disease Management, Risk Sharing*, 13 BUS. & HEALTH 46 (1995) ("[U]nder such arrangements the pharmaceutical company shares the risk for a successful outcome. In one such arrangement, the drug company refunds money to the insurer if the patient's symptoms worsen after use of a drug sold to the insurer.").

167. *See* Sanders, *supra* note 118, at 112 ("The physician acts as a check on the traditional insurer because he will at least alert the patient to the fact that care is indicated."); Randall, *supra* note 4, at 34 ("Historically, we have seen how the profit motive worked to increase utilization. There is no reason to think that similar dysfunctions will not occur in a system designed to enhance profits by decreasing utilization." (footnote omitted)).

168. *See* Mollyann Brodie & Robert J. Blendon, *The Public's Contribution to Congressional Gridlock on Health Care Reform*, 20 J. HEALTH POL. POL'Y & L. 403, 403-04 (1995) (noting that growing number of uninsured, among other things, contributed to middle class concerns about health care and that such concern was a factor in the health care reform debate).

to take advantage of the law of large numbers and risk pooling, which is the fundamental principle upon which insurance operates.[169] To the extent that a more honest approach is taken to contain costs, we would be forced into undertaking the data collection necessary to provide a good set of clinical practice protocols.[170]

In this context, the old dogma—the prohibition on the corporate practice of medicine—assumes a new purpose. It would maintain a separation of function. Insurers should insure, physicians should treat patients, and conflicts between the two should not be subverted. The corporate practice doctrine would prevent insurers from exporting part of their costs to physicians. Exportation of their costs allows the industry to operate as if it can offer a viable product in a profitable business. Health coverage is a viable product only if it is subsidized. Resurrection of the corporate practice doctrine would prevent exportation of the costs of doing business in the health financing field. This would reveal that provision health care coverage through the private market is inefficient.

Another useful purpose for a reassertion of the corporate practice doctrine would be to repair the damage to the fiduciary relationship between the patient and the physician. One original purpose of the doctrine was to prevent the commercialization of the medical profession.[171] Preventing commercialization would engender public trust in the profession.[172] Under utilization review, the physician can still function as a fiduciary.[173] However, to the extent that risk sharing becomes more prevalent and knowledge about its prevalence in health care financing spreads to the public, the public becomes less trustful of physicians' financial motives.[174] Although the empirical evidence does

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169. *See* Mark A. Hall, *The Role of Insurance Purchasing Cooperatives in Health Care Reform*, 3 KAN. J.L. & PUB. POL'Y 95, 98 (1993-94) ("According to the statistical Law of Large Numbers, the ability to predict accurately the actual loss a group will suffer decreases as the group becomes smaller; therefore, small risk pools require a larger risk premium per equivalent expected loss than do larger groups.").

170. *See* The Health Care Study Group, *Report: Understanding the Choices in Health Care Reform*, 19 J. HEALTH POL. POL'Y & L. 499, 527 (1994) ("Treatment protocols are standard procedures for diagnosing disease, given certain symptoms, or treating disease, given a diagnosis. . . . They require detailed and expensive studies involving large numbers of patients and controls.").

171. *See* Alanson W. Willcox, *Hospitals and the Corporate Practice of Medicine*, 45 CORNELL L. Q. 432, 446 (1960).

172. *See, e.g.*, Bartron v. Codington County, 2 N.W.2d 337, 346 (S.D. 1942) ("[A]n ethical, *trustworthy* and unselfish professionalism as the community needs and wants cannot survive in a purely commercial atmosphere." (emphasis added)).

173. *See* Sanders, *supra* note 118, at 112 (noting that under traditional insurance, a physician acts as a check on the traditional insurer because the physician will alert the patient to the need for care).

174. *See* Mechanic & Schlesinger, *supra* note 9, at 1694 ("[T]he limited evidence available suggests that many [patients] are uncomfortable with incentives that require physicians to balance the benefits of their medical care against the costs that it engenders for the plan. Thus, payment arrangements could significantly undermine patients' beliefs that their physicians are acting as their agents.").

not indicate that risk sharing has caused a deterioration in the quality of patient care,[175] stories abound in the popular media based on the assumption that physicians' decision making is impaired because of negative financial inducements.[176] The idea that people cannot trust their physicians yields a rather different system for delivering health care than a system based on an assumption of trust. It should be noted that the "quality" of health care has a psychic, as well as concrete, dimension and that this quality can be diminished if the patient does not trust the physician.[177]

There are some advocates for altering the patient-physician relationship. They believe that the cost spiral in medicine was the result of the paternalistic[178] relationship between patients and physicians.[179] The physician talked, the patient listened without question. The physician prescribed medication which the patient ingested without question. The patient endured surgical procedures without a thought about obtaining a second opinion. The problems with the costs of health care resulted from the unwavering trust that the patient placed in the physician's decision making. According to these advocates, it would not be a such a bad thing to have patients assume a more "arm's length" relationship with physicians and become more questioning, more informed consumers of health care services.[180]

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175. *See supra* note 129.

176. *See supra* note 128.

177. *See* Capron, *supra* note 125, at 737-38 ("It has even been found that many patients experience therapeutic benefits resulting from trust in their physician and her judgment." (citing E. FREIEDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE 263-68 (1970))); *see also* RODWIN, *supra* note 26, at 153 (noting that incentives give patients reason to doubt their physician's neutrality and thereby weaken the informed consent process).

178. *See* Hall, *supra* note 21, at 728 ("[T]he central value of professionally dominated medical ethics is patient well-being, traditionally defined in a highly paternalistic and authoritarian fashion.").

179. *See, e.g.*, Hall, *supra* note 21, at 729-31. Professor Hall describes a school of medical ethics described as the "beneficence" school. Underlying this school was the thought that the physician would direct the patient in the selection of treatment options. For this school, the patient's trust in the physician was required. This required the physician to be above concerns about the costs of treatment. Hall indicates that such a model "fits only the comprehensive, unregulated, fee-for-service type of insurance that dominated prior to 1980. It is precisely this form of insurance, however, that is driving up the costs of treatment to the extent that insurance is unaffordable for tens of millions." *Id.* at 731; *see also* John A. Siliciano, *Wealth, Equity and the Unitary Medical Malpractice Standard*, 77 VA. L. REV. 439, 449 (1991) ("The physician-patient relationship . . . was paternalistic and fiduciary in nature, and thus encouraged health care consumers to acquiesce in the decisions of their physicians.").

180. *See* Maxwell J. Mehlman, *Medical Advocates: A Call For a New Profession*, 1 WIDENER L. SYMP. J. 299, 310. In this article, Mehlman describes a "consumerism" approach (with which he disagrees). According to Mehlman, under this consumerism approach:

> [T]he emphasis is on self-reliance. Patients are repeatedly being urged to protect their interests themselves. "Choose your physician or health plan wisely," they are told. According to this consumerism approach, patients should arm themselves with information, often obtaining it from the health plans or providers themselves, and make informed, self-

However, to the extent that such an arm's length relationship would be better, this does not mean that this relationship should be fostered by the introduction of subtle negative financial considerations into the physician-patient relationship. Utilization review, despite its perceived shortcomings, provides the opportunity for an arm's length relationship by subjecting a physician's decision to an external second opinion. Ideally, this second opinion will be informed by the best available current treatment protocols. This would be a much better approach to correcting the perceived abuses arising from a paternalistic physician-patient relationship than a subterranean process that relies on patients' unhealthy suspicions about their physicians' financial motives. Indeed, such suspicion diminishes the quality of care. Reassertion of the corporate practice doctrine could reestablish the trust by removing the appearance of impropriety.

VII. THE FEDERAL RESPONSE TO RISK-SHARING ARRANGEMENTS

The current federal approach to health care cost recognizes the connection between financial benefit to physicians and their decision making. Federal policy recognizes that financial inducements can yield overutilization of health care resources. Thus, federal policy has implemented rules to disrupt this causal relationship in the form of outright prohibitions on certain types of financial arrangements that have the potential to cause overutilization of health care resources. On the other hand, the federal government has been slow to recognize that negative financial inducements inherent in capitation and fee withholding have the potential to cause underutilization of services. In effect, the federal response is asymmetrical. It prohibits financial relationships that induce overutilization on one hand, but tolerates financial relationships that could cause underutilization, on the other.

Under the corporate practice doctrine, a court did not have to determine that the conflict of interest actually resulted in a negative consequence for the patient or that because of the conflict of interest the physician ever actually acted in a manner that was not in the patient's best interest.[181] According to the doctrine, the risk of abuse was so great

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interested choices.

Id.; *see also* E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 AM. J. L. & MED. 79, 102 (1994) (describing benefits of a system in which patients motivated by economic consequences of care decisions interact with physicians on a more informed basis).

181. *See, e.g.*, Bartron v. Codington County, 2 N.W.2d 337, 346 (S.D. 1942) ("Though the exhibited instance of that conduct [referring to a corporate practice arrangement] has accomplished no evil, if its inherent tendency be at war with public interest, it is contrary to public policy.").

as to justify barring the arrangement that would create the potential for abuse.[182] In other words, the best protection was removing temptation altogether.

The federal government uses the same approach of removing temptation when addressing financial transactions that have the potential for causing overutilization of services. Studies have indicated that Medicare beneficiaries treated by physicians who owned or invested in independent clinical laboratories received forty-five percent more laboratory services from the independent clinical laboratories than Medicare beneficiaries in general.[183] These results supported the premise that, if it is to a physician's economic advantage, the physician will overutilize services. Therefore, federal law imposes preventative measures by prohibiting relationships that create the potential for excessive utilization.

Hence, federal legislation broadly proscribes transactions and relationships that have the potential to lead to overutilization of medical services. Under Stark II,[184] a physician is prohibited from making

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182. *See id.*

183. *Issues Related to Physician "Self-Referrals:" Hearings on H.R. 939 Before the Subcomm. on Oversight of the Comm. on Ways and Means*, 101st Cong. (1989) (testimony of Michael Zimmerman, Director, Medicare and Medicaid Issues, Human Resources Division of the U.S. Government Accounting Office).

184. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (codified as amended at 42 U.S.C. § 1395nn (1995)); Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-6, 107 Stat. 596 (codified as amended at 42 U.S.C. § 1395nn (1994)). Section 1395nn provides, in pertinent part:

> Limitation on certain physician referrals
>
> (a) Prohibition of certain referrals
>
> (1) In general
>
> Except as provided in subsection (b) of this section, if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then —
>
> (A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and
>
> (B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).
>
> (2) Financial relationship specified
>
> For purposes of this section, a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in this paragraph is —
>
> (A) except as provided in subsections (c) and (d) of this section, an ownership or investment interest in the entity, or
>
> (B) except as provided in subsection (e) of this section, a compensation arrangement (as defined in subsection (h)(1) of this section) between the physician (or an immediate family member of such physician) and the entity.

referrals for the furnishing of designated health services for which payment may be made under the Medicare or Medicaid program to any entity with which the physician has a financial relationship.[185] Under the Medicare and Medicaid Fraud and Abuse statute,[186] it is illegal to solicit or receive any remuneration in return for referring a patient for services.[187] Although there are exceptions to each of these laws, the exceptions recognize that any compensation or benefit flowing to the physician in excess of the fair market value for services rendered by the physician presents a potential for overutilization.[188] Therefore, the

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Id.

185. *See id.*

186. Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, 91 Stat. 1175 (1977) (codified as amended in scattered sections of 42 U.S.C.).

187. Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (codified as amended 42 U.S.C. 1320a-7b (1988)). The anti-kickback statute provides in pertinent part as follows:

> (b) Illegal remunerations
>
> (1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind —
>
> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [Medicare or Medicaid], or
>
> (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [Medicare or Medicaid],
>
> shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years or both.
>
> (2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person —
>
> (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [Medicare or Medicaid], or
>
> (B) to purchase, lease, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under subchapter XVIII of this chapter or a State health care program,
>
> shall be guilty of a felony . . .

42 U.S.C. 1320a-7b(b) (1988 & Supp. V 1993).

188. *See* 42 C.F.R. § 1001.952 (1996). This "safe harbor" provides that the anti-kickback law is not violated if, among other things:

> The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or [Medicaid] . . . .

Id.

> [T]he term *fair market value* means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may

exceptions are narrowly drawn to eliminate any excess compensation. For example, a physician may lease office space from a hospital to which the physician admits patients and not violate the anti-referral laws if the physician leases the space at its fair rental value. However, if the hospital subsidizes the physician's rent by offering the physician below-market lease rates, the law would be violated.[189]

The federal government has clearly acknowledged that there may be a connection between financial inducements and overutilization of health care services. It has addressed this situation by prohibiting financial arrangements that have the potential to cause physicians to overutilize health care resources. If it is true that financial inducements can increase utilization, is it also not true that financial incentives can cause physicians to underutilize services?

The federal government has not approached the potential problems with negative financial inducements with the fervor that it has used to address positive financial inducements.[190] The federal government acknowledges that there is a potential for negative inducements to cause physicians to underutilize health care resources.[191] However, instead of broadly prohibiting such inducements, the federal government draws a line between permissible and impermissible negative financial inducements in an attempt to preserve risk sharing. Thus, in 1986, Congress amended the Medicare statute to prohibit hospitals and HMOs from making direct or indirect payments to physicians for the purpose of inducing physicians to reduce services to Medicare beneficiaries.[192] Risk-sharing mechanisms have the purpose of reducing physicians' utilization of health care resources. Therefore, this prohibition would probably invalidate these risk-sharing mechanisms.

Outlawing risk-sharing mechanisms, however, would amount to an abandonment of twenty years of policy making pursuant to which the

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be made in whole or in part under Medicare or [Medicaid] . . . .

Id.

189. *Id.*

190. *See id.* (noting that the breadth of the Medicare-Medicaid Anti-Fraud and Abuse Statute has caused considerable concern among health care providers that "many relatively innocuous, or even beneficial commercial arrangements are technically covered by the statute and are, therefore, subject to criminal prosecution.").

191. *See* Haney & Bayles, *supra* note 2 (citing United States General Accounting Office report which concluded that "[i]ncentive plans may offer such strong financial incentives to physicians to reduce utilization that quality of care could be adversely affected through the withholding of needed services").

192. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 913 (c)(1)(E), 100 Stat. 1874, 2003 (1986) (codified as amended at 42 U.S.C. § 1320a-7a). Previously, the statute only applied to hospitals. Subsequently, Congress amended 42 U.S.C. § 1320a-7a(b)(1) again to delete references to HMOs. *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4731(b)(1), 104 Stat. 1388, 1388-95.

federal government has condoned financial risk-sharing arrangements. In the Federal HMO Act of 1973, the federal government acknowledged the role that risk sharing might play in the development of HMOs. The Federal HMO Act requires HMOs to assume full financial risk on a prospective basis for the provision of basic health services; however, the Act specifically authorizes provider risk sharing as a means to meet this responsibility.[193] In addition, the federal government itself introduced a type of risk sharing for Medicare through its introduction of the diagnosis related grouping (DRG) compensation methodology in 1983.[194] DRG compensation altered the traditional fee-for-service methodology that had been used to compensate hospitals. Under DRG, the hospital would be entitled to a predetermined amount for each patient encounter dependent upon the patient's admission diagnosis. This represented a type of risk sharing because the hospital would only get a set fee regardless of how long it took to treat the patient. The risk assumed by the hospital was that it might lose money on the patient.

Risk sharing has permeated federal thinking about health care cost containment. For example, the response to physicians' desire to combine forces to combat the market power exercised by payers was to create an antitrust safe harbor for physicians who, among other things, share substantial financial risk.[195] In other words, if physicians desire to

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193. *See* 42 U.S.C. § 300e(c)(2)(D) (1994). HMOs may make "arrangements with physicians or other health professionals, health care institutions . . . to assume all or part of the financial risk on a prospective basis for the provision of basic health services . . . ." *Id.* Furthermore, federally qualified HMOs dealing with the Medicare program must have "effective procedures to monitor utilization and to control cost of basic and supplemental health services and to achieve utilization goals, which may include mechanisms such as risk sharing, financial incentives, or other provisions agreed to by providers." 42 C.F.R. 417.103(b)B (1996).

194. *See* Thomas Bodenheimer, *supra* note 20, at 976.

> [U]nder DRGs Medicare pays the hospital a lump sum for each hospital admission, with the size of the payment dependent on the patient's diagnosis. . . . DRG reimbursement lumps together all services performed during one hospital episode. . . .
>
> Under the DRG system . . . the hospital is at risk for the length of hospital stay and for the resources used during the hospital stay.

Id.

195. *See* Department of Justice and Federal Trade Commission Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, *reprinted in* 3 BNA Health L. Rep. 1376, 1391 (Sept. 27, 1994). Statement No. 8 of the Department of Justice and FTC statements relates to physician network joint ventures. *See id.* The Statement notes that physician-controlled networks, which would otherwise be subject to antitrust enforcement for collectively agreeing on prices or other significant terms of competition, will not be challenged, if, among other things, the physicians in the group "share substantial financial risk." *Id.* at 1392. Sharing substantial financial risk may be:

(1) when the venture agrees to provide services to a health benefits plan at a "capitated" rate; or

(2) when the venture creates significant financial incentives for its members as a group to achieve specified cost-containment goals, such as withholding from all members a

jointly act against a payer, they need to share financial risks. The FTC and the Department of Justice indicate that physicians may share substantial financial risk by accepting a capitation agreement or by having their fees subject to a substantial withhold with the return dependent upon the entity meeting its cost saving goals.[196]

Given this history of support for risk sharing, the federal government needed to find a means to preserve risk sharing despite its acknowledged potential problems. Therefore, at the same time that Congress included HMOs in the prohibition, Congress delayed implementation of penalties against HMOs and instructed the Secretary of the Department of Health and Human Services (HHS) to develop some guidelines for risk sharing that would not violate the statute.[197] Subsequently, Congress repealed application of the strict prohibition as it applies to HMOs and instead adopted a more lenient standard for HMOs.[198] Under the applicable standard, an HMO is prohibited from operating a plan under which a "specific payment is made directly or indirectly . . . to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization."[199] The statute does not prohibit risk-sharing arrangements: "If the plan places a physician or group at substantial financial risk (as determined by the Secretary) for

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> substantial amount of the compensation due to them, with distribution of that amount to the members only if the cost-containment goals are met.

Id. (footnote omitted).

196. *See id.*

197. Omnibus Budget Reconciliation Act (OBRA) of 1986, Pub. L. No. 99-509, § 9313(c)(1)(E), 100 Stat. 1874, 2003-04.

> The Secretary of Health and Human Services shall report to Congress, not later than January 1, 1988, concerning incentive arrangements offered by health maintenance organizations and competitive medical plans to physicians. The report shall:
>
> (A) review the type of incentive arrangements in common use,
>
> (B) evaluate their potential to pressure improperly physicians to reduce or limit services in a medically inappropriate manner, and
>
> (C) make recommendations concerning providing for an exception, to the prohibition contained in section 1128A(b) of the Social Security Act [the U.S.C. 1320a-7a(b) prohibition of payments to induce care reductions, for incentive arrangement to induce care reductions], for incentive arrangements that may be used by such organizations and plans to encourage efficiency in the utilization of medical and other services but that do not have a substantial potential for adverse effect on quality.

Id. A series of amendments eventually delayed implementation of the HMO-related penalties until April 1, 1991. *See id.* § 9313(c)(E), 100 Stat. at 2003 (setting implementation date as April 1, 1989); OBRA of 1987, Pub. L. No. 100-203, § 4016, 101 Stat. 1330-64, 1330-64 (amending implementation of Pub. L. No. 100-203 to April 1, 1990); OBRA of 1988, Pub. L. No. 101-239, § 6207(a), 103 Stat. 2106, 2245 (amending implementation of Pub. L. No. 100-203 to April 1, 1991).

198. OBRA of 1990, Pub. L. No. 101-508, §4731, 104 Stat. 1388, 1388-195.

199. *Id.* (codified as amended at 42 U.S.C. § 1395mm(i)(8)(A)(ii)(I)).

services not provided by the physician or physician group," the organization must provide "stop-loss protection."[200]

In other words, the Secretary of HHS is charged with drawing a line between permissible and impermissible negative inducements. The Secretary must answer the question of what amount of financial risk will not cause the physician to underutilize health care resources. This is a rather misguided exercise. The appropriate guideline would be an amount of financial risk that would prevent a physician from rendering medically unnecessary services, but that would not cause the physician to withhold medically necessary services. This would appear to require pinpoint accuracy which, in turn, would require access to a numerical cause and effect relationship that is not only unknown, but perhaps unknowable.

In order to define substantial financial risk, HHS examined the various risk-sharing compensation systems in effect in the market.[201] HHS noted that the key feature involved in financial risk systems was a differential between the potential high and low compensation that physicians could receive under any particular system. Under these systems, depending on the physician's attainment of the HMO cost-

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200. 42 U.S.C. § 1395mm (i)(8)(A)(ii)(I). "Stop loss" is a device for limiting the physicians' losses to a designated dollar amount. *See* Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 57 Fed. Reg. 59024, 59026 (1992).

> Many physicians incentive plans incorporate stop-loss protection to limit the liability of the physician or physician group. Most often, the stop-loss protection limits a physician's maximum liability per patient to a specific dollar amount. . . . In some cases, prepaid health care organizations place an aggregate limit on the liability the physician could face. . . . Stop-loss protection is particularly common with capitation arrangements.

Id.; *see also* DAVID W. LEE, CAPITATION: THE PHYSICIAN'S GUIDE 20 (1995) ("Reinsurance or stop-loss: An insurance plan in which the insurer agrees to share or assume treatment costs that exceed a predefined threshold amount."). Under the statute, a managed care organization would be responsible for providing such stop loss by either committing to cover the excess liability itself or purchasing a reinsurance policy, or reimbursing the physician for the expenses associated with a reinsurance policy. Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 57 Fed. Reg. at 59032.

> The organization can either provide or buy the stop-loss protection, or the physician or physician group can obtain the protection.
>
> . . . .
>
> . . . Since the legislation requires the organization to provide the stop-loss, we [the Department of Health and Human Services (HHS)] are requiring the organization to pay the cost of the portion of stop-loss protection that covers its enrollees in the physician incentive plan, or increase the amount of stop-loss protection to account for the physician's cost for stop loss.

Id.; Thus, by defining "substantial financial risk," the Secretary of HHS would place a limit on the degree of risk shifting that an entity could engage in with a physician or group of physicians. The entity which places physicians at a substantial risk was also obligated to conduct periodic surveys of its membership in order to "determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of services." 42 U.S.C. § 1395mm(i)(8)(A)(ii)(II).

201. *See* Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 57 Fed. Reg. at 59,025-26, 59,028.

containment goals, the physician's net income could vary. For example, if the system provided for a twenty percent fee withhold to pay for the services of specialists and for in-patient hospital services, the physician could get back all or none of the withheld fees depending on the cost performance—this represented a twenty percent differential between the low and high compensation that the physician could receive. HHS defined substantial financial risk for organizations that assess or distribute incentive payments more than once a year as twenty-five percent, and for organizations that assess or distribute incentive payments more than once a year as fifteen percent.[202]

The effect of the proposed rule would be to set a limit on the degree of risk sharing that HMOs could impose on physicians. In the event that the HMO assessed the incentive arrangement not more than once a year, the HMO could not implement a plan that exposed more than twenty-five percent of the physician's income to risk for services not provided by the physician. The HMOs would need to provide stop-loss coverage for the physicians to prevent their losses.

In order to determine that twenty-five percent was the appropriate risk threshold, HHS observed that, in the market it surveyed, withholds of twenty-five and thirty percent represented the upper ranges used under typical circumstances.[203] In addition, HHS relied on the fact that Group Health Associations of America identified the median withhold percentage as twenty percent.[204] The agency justified its selection of the twenty percent threshold because:

(1) It represented an industry standard which appeared to be acceptable to physicians;
(2) Physicians were typically known to shoulder a risk of bad debt exposure of up to 20% of their fees;
(3) Physicians were known to customarily discount their fees by 20%.[205]

Therefore, the agency reasoned:

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202. *Id.* at 59,027. HHS established two risk thresholds because:

> [T]he shorter the timeframe over which incentive arrangements assess a physician's or a physician group's performance, the more influence the incentive arrangement will have. This is because physicians or physician groups have fewer patients in a short timeframe over which to spread the risk of expensive treatment than in a long timeframe. Since these types of arrangements have the potential to have a stronger influence on physician behavior, we believe that the lower risk threshold [15%] is appropriate.

Id. at 59,030.

203. *See id.* at 59,028.

204. *See id.* This was based on a Group Health Association survey conducted in 1987. *See id.*

205. *Id.* at 59,028, 59,031.

> [F]inancial incentive plans that place physicians or physician groups at risk for 25 percent of their payments . . . would appear to be of the same magnitude as the reduction in payments many physicians voluntarily accept in return for increased volume and protection against bad debt, and in response to market place competition.[206]

This reasoning is flawed. If the goal of the regulations is to protect against the potential negative consequences of risk shifting, the market does not provide the best point of reference. By adopting the median withhold that its survey revealed existed in the marketplace, in effect, HHS defined substantial risk as risk in excess of what the average physician has accepted in a marketplace in which the physician is at a negotiating disadvantage.[207] In other words, substantial risk is excess of what the market would bear. Basically, HHS proposed to adopt the industry norm as the threshold figure and relied on the fact that no discernible problems with patient care had arisen in the market.[208]

It is equally unreasonable to use a physician's acceptance of a twenty percent bad-debt experience to establish an acceptable threshold for determining substantial financial risk. Unlike risk-sharing mechanisms that place the physician's income at risk, the fact that the physician's bad debt is ten to twenty percent does not have the potential for inducing a physician to reduce services. Bad debt expense is, to a degree, something that is uncontrollable prior to rendering the service. It is within the physician's power to ensure that withheld fees are returned.

Along similar lines, the fact that physicians discount their fees by as much as twenty percent does not mean that a twenty percent fee withhold or other risk-sharing mechanism will not necessarily cause physicians to withhold medically necessary services. It has been observed that physicians will make up for discounts by increased volume of services. Also, the acceptance of a twenty percent discount has an air of inevitability about it—it is the product of absence of negotiating power that the physician accepts on a take-it-or-leave-it basis. Physicians may be able to control the loss of income resulting from risk sharing by withholding medically necessary services. In addition, HHS itself acknowledged the possibility that the withholds are typically not applied against the usual and customary physician's fees, but against fees that have already been discounted.[209]

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206. *Id.* at 59,028.

207. *See supra* notes 153-54 and accompanying text relating physicians' disadvantage when negotiating risk-sharing arrangements.

208. *See id.* ("[T]here is no evidence that conventional physician incentive plans . . . have reduced access or caused quality of care problems.").

209. *Id.* at 59,031 ("[W]e are concerned that such discounts may be factored into the plan's payments

The federal government's approach to risk sharing involves a shaky acceptance of the practices in the marketplace. This is done to preserve risk sharing, but also to curb its potential harm. In adopting this approach, the federal government can take comfort in the fact that empirical evidence seems to bear out the fact that the use of financial incentives has not reduced the quality of care for patients.

Just as private sector payers, the government has an interest in risk sharing as a means to lower its costs of providing health benefits. Risk sharing allows implicit rationing. The federal government is no more interested in explicit health care rationing than the private sector payer.[210] Therefore, the federal government is acting as a prudent payer of health care services; thus, it makes sense for the government to tolerate mechanisms used to shift some of the risk of providing health coverage to third parties. This also explains the growth in Medicare, Medicaid, and managed care plans under the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS).[211] This strategy, however, allows managed care organizations that accept Medicare risk contracts to export part of the cost of insuring beneficiaries of federal programs onto providers of health care services. In this manner, the federal government allows the private health care system to operate with the benefit of a hidden subsidy. If the federal government would embrace the corporate practice of medicine doctrine, it would curtail this hidden subsidy and would awaken the government, as well as private industry, to the true costs of doing business in the current fragmented system of health care financing.

VIII. SOLUTIONS TO THE POTENTIAL PROBLEMS WITH RISK SHARING

As developed throughout this Article, reassertion of the corporate practice of medicine doctrine would curtail risk-sharing arrangements. This would have the effect of requiring different actors in the health care financing system to shoulder their own costs of doing business and not receive hidden subsidies. This would be beneficial for a number of reasons, including restoration of trust between physicians and patients,

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to the physician or physician group. If so, the 25-percent risk would be applied to an already discounted amount, which may not be reasonable.").

210. *See, e.g.*, David L. Weigert, *Tragic Choices: State Discretion Over Organ Transplant Funding For Medicaid Recipients*, 89 Nw. U. L. Rev. 268, 296-97 (discussing the federal government's historical reluctance to ration health care due to the "symbolic blackmail" involved when an identifiable life will be affected by the explicit decision to deny payment for medically necessary but expensive services).

211. *See supra* note 31 and accompanying text.

preventing implicit rationing of health care services, and forcing a more honest debate about health care financing. However, policy makers and commentators have proposed solutions to address risk sharing by methods other than outright prohibition. The idea appears to be that we can control the problem if we can tame it. We can tame it if we can name it; therefore, some proposals are directed at having disclosures made to patients about the risk-sharing relationships.[212] Other commentators believe that risk sharing does not pose a significant problem because the tort system could punish financially motivated decisions, and because physicians must act so as to avoid losing their licenses.[213]

Disclosure of risk-sharing arrangements would be an ineffective solution. Such a disclosure cheapens the physician-patient relationship, thereby further undermining the patient's trust in the physician. This tends to exacerbate, rather than ameliorate, the problems associated with risk-sharing arrangements. This could lead to additional questioning about physicians' decisions, which would introduce even further inefficiency into the system. This disclosure also does not benefit patients because there may be nothing that they could do with the information that is relevant to curtailing the potential abuse. To the extent that these forms of risk sharing are prevalent, the patient does not have the option of seeking providers that are not covered by a risk-sharing arrangement.[214]

It has been argued that risk sharing does not cause physicians to underutilize medical services because of the threat of liability or professional sanctions.[215] Therefore, risk sharing does not provide any real danger to the patients. The tort system will serve as an effective deterrent to abuse of risk-sharing arrangements.

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212. *See, e.g.*, McGraw, *supra* note 7; Mary Anne Bobinski, *supra* note 25, at 387 ("Disclosure may be a particularly important tool to protect consumers as our health system evolves.").

213. *See* Hall, *supra* note 21, at 766 (arguing against the inadequacy of disclosure requirements by noting, among other things, the possibility of tort claims).

214. *See* Mechanic & Schlesinger, *supra* note 9, at 1694.

> [P]atients would be placed in a difficult position of trying to interpret what they were told, trying to understand the implications of different risk pools, and/or trying to assess the consequences of financial risk. Even if they do understand, many patients face restricted options because of lack of choice or few significant differences among the plans available to them.

Id.; *see also* McGraw, *supra* note 7, at 1845 ("[A]t the moment the patient is deciding whether to adopt a physician's treatment recommendation, the information about possible financial conflict of interest may come too late. The patient is already enrolled in the insurance plan, and may not be able to seek care elsewhere.").

215. *See* Hall, *supra* note 21, at 766.

However, the courts have been loath to recognize the connection between risk sharing and a patient's injuries. There are few reported cases in which the connection between the compensation arrangement and some perceived harm has been raised. Other than the case *Bush v. Dake*,[216] plaintiffs have uniformly been denied the ability to present the connection to the jury. It is as if the courts have been afflicted by a collective amnesia induced by twenty years of cost-containment oriented policy making, which has made them forget the perils of lay interference with physician decision making.

In *Sweede v. Cigna Healthplan of Delaware, Inc.*,[217] the plaintiff alleged that the physician committed gross negligence by failing to timely refer her to a surgeon when it was discovered that she had a lump in her breast. The plaintiff alleged that the physician's delay in making the referral was influenced by financial incentives in Cigna's compensation arrangement with the physician. Her allegation was that Cigna's system of capitation and fee withholding induced her physician to withhold her care. The plaintiff claimed punitive damages because the defendant recklessly delayed referring the plaintiff to a surgeon because of the financial incentives. In the court's view, "[t]he number of referrals or hospitalizations made by any one individual physician does not control whether that physician will receive a return of his withholds."[218] Therefore, the court ruled that any connection between Cigna's capitation-withhold policy and the physician's decision regarding referring the plaintiff to a surgeon was "too remote to be of significant probative value."[219] According to the court, the facts, taken together, did not support submitting the question of punitive damages to the jury.

Teti v. U.S. Health Care involved a claim under the Racketeer Influenced and Corrupt Organizations Act (RICO) against an HMO by its enrollees.[220] The basis of the enrollees' claim was that the HMO had concealed from them the existence of risk-sharing arrangements with the HMO's physicians.[221] The enrollees claimed that the concealment constituted a pattern of fraudulent nondisclosure violative of RICO. The court dismissed the RICO claim, reasoning that RICO requires an

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216. *Bush v. Dake* is an unpublished opinion which is reprinted in FURROW ET AL., *supra* note 2, at 384.

217. 1989 WL 12608 (Del. Super. Ct. 1989).

218. *Id.* at *5.

219. *Id.*

220. Teti v. U.S. Healthcare, Inc., Nos. 88-9808, 88-9822, 1989 U.S. Dist. LEXIS 14041, at *1 (E.D. Pa. Nov. 20, 1989).

221. *See id.* at *2-3.

enterprise operated for the furtherance of crime and that the plaintiff had failed to raise a genuine fact issue on this point.[222]

In *Pulvers v. Kaiser Foundation Health Plan, Inc.*,[223] the plaintiffs alleged that the Kaiser Permanente HMO committed fraud in the enrollment process by holding itself out as "nonprofit" when its physicians were covered by financial incentive arrangements. The plaintiffs alleged that the physicians acted "for profit" in a nonprofit HMO.[224] The court held that the incentive plans are recommended by professional organizations and required by the Federal HMO Act of 1973. According to the HMO Act, HMOs must have effective procedures to monitor utilization, to control cost of basic and supplemental health services, and to achieve utilization goals, which may include mechanisms such as risk sharing, financial incentives, or other provisions agreed to by providers.[225]

Madsen v. Park Nicollet Medical Center[226] was a medical negligence case. The plaintiff attempted to introduce evidence that a pregnant mother's status as an HMO member meant that her hospitalization could have adversely affected the physician's profit. The plaintiff wanted the jury to consider whether this factor contributed to her physician's failure to inform her about the need for hospitalization.[227] The court upheld the lower court's decision to exclude this information noting that the information "was only marginally relevant, and potentially very prejudicial."[228]

These cases indicate that the courts may be rather reluctant to recognize any connection between physicians' financial incentives and medical injuries. However, even if the courts could recognize such a causal relationship, using the tort system to police quality would misplace the burden. It would mean that the physicians would bear the legal liability for activities that benefit the payers. This misplaced burden is exacerbated by that fact that ERISA preempts state law causes of action arising from the denial of benefits by managed care plans providing health coverage pursuant to an employer-sponsored health benefit plan.[229]

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222. *See id.* at *4.

223. 99 Cal. App. 3d 560 (Cal. Ct. App. 1979).

224. *Id.* at 565.

225. *Id.*

226. 419 N.W.2d 511 (Minn. Ct. App. 1988), *rev'd on other grounds*, 431 N.W.2d 855 (Minn. 1988). The plaintiff in this case was the father. *See id.* at 512. He alleged that the mother of his son had been negligently treated during pregnancy. *See id.*

227. *See id.* at 515.

228. *Id.*

229. *See, e.g.*, Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1332 (5th Cir. 1992) (holding that

Furthermore, reliance on the tort system does not yield the appropriate answer if the goal is to reduce medically unnecessary care. Is the treatment decision that is the end result of the interplay between negative financial inducements on the one hand, and the threat of malpractice suits on the other hand, the right decision, or only the expedient decision? This seems like a rather ingenuous and circuitous method of eliminating medically unnecessary care.

IX. CONCLUSION

The corporate practice of medicine doctrine helped to improve the reputation of organized medicine in the United States. The doctrine prohibited entanglements between the physicians' exercise of their professional judgments and the profit-making endeavors of lay organizations. The purpose of the doctrine was to maintain the physician's independence and help the physician operate as a fiduciary. However, the doctrine also had anticompetitive consequences that caused the federal government to implement policies which undermined the doctrine. This has allowed cost containment to proceed in a manner that allows payers to export the costs of doing business to providers of health care services. The exportation of costs represents a hidden subsidy to the private insurance industry. This subsidy is maintained at the expense of the integrity of the patient-physician relationship. It combines in one decision maker inherently antagonistic functions. This involves physicians in the insurance function and thereby undermines the fiduciary relationship between patients and their physicians. The federal government has condoned and promoted risk-sharing arrangements and has taken the position that it can protect patients from the abuse of risk sharing by stipulating a magic threshold for risk sharing. As long as the federal government declines to heed the message of the corporate practice doctrine, the search for health care cost containment will yield approaches that are dangerous or dishonest, or both.

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patient state law claim against HMO based on denial of benefits was preempted by ERISA). *See supra* notes 159-63 and accompanying text for background on ERISA.